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ABSTRACT

The Rural Texas Domestic Violence Health Professionals Education Program (RTDVHPEP) was designed as an initial and circumscribed effort in the establishment of a comprehensive network of services for Texas victims of rural domestic violence. Immediate goals of RTDVHPEP were to provide rural health care professionals with knowledge and skills to identify domestic violence victims, utilize and coordinate existing services and resources, create needed services, and design local networks. Rural health providers who participated in the five RTDVHPEP conferences developed increased awareness of their role as community change agents and became familiar with the network of existing domestic violence services. This led to development of working relationships between rural health providers and domestic violence service providers, thus creating/expanding local services, strengthening the existing service network, enhancing public awareness, and helping to foster social change. Program achievements included increased statewide awareness of rural domestic violence, creation of new services, improvement of existing services, creation of a nonmetropolitan health/human service provider database, compilation/analysis of rural domestic violence research data, development of local/regional/state networks, organization of 5 conferences for 612 health/human service providers, development of tools for rural health/human service providers, and creation of a model for a cost-effective, high-impact education program. (MH)

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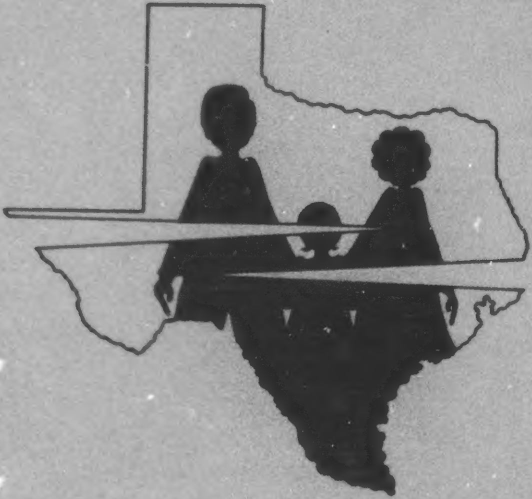

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# The Rural Texas Domestic Violence
# Health Professionals Education Program

## Final Report

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November 1983

Rural Texas Domestic Violence
Health Professionals Education Program

**Final Report**

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We sincerely appreciate the enthusiastic welcome and hard work of the communities and co-sponsors of each conference. The special contributions of local conference coordinators Lisa Pate, Linda Mast, Kim Robinson, Teresa Edwards, and Pamela Bowman are gratefully acknowledged.

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It is impossible to single out all those whose time and energy made the Rural Texas Domestic Violence Health Professionals Education Program so successful, but we thank each of you for your contribution.

# INTRODUCTION

> "...In rural areas where 'everyone knows everyone'
> domestic violence is possibly ignored even more
> than in urban areas."[1]

Domestic violence is a serious, yet often neglected and misunderstood, mental health problem in rural Texas. Complicating this is the scarcity of rural health professionals* and a lack of rural health care providers who are skilled in the delivery of health services to victims of domestic violence. This combination of problems has resulted in inadequate or nonexistent domestic violence services and service networks in rural communities in Texas.

The Rural Texas Domestic Violence Health Professionals Education Program began June 1, 1982 and ended September 30, 1983. Over this 14 month period activities included the identification of program participants, and the administration of a statewide survey to determine the educational needs of rural health providers and community attitudes about family violence. An educational format for training rural health and human service providers was designed and with input from domestic violence experts, health/human service providers and rural communities, conference guidelines were developed. With the completion of five very successful conferences, the education of over 600 rural health providers, and the media coverage, thousands of rural Texans were made aware of the conferences, the need for education and the extent of the domestic violence problem in their regions and in Texas as a whole.

In addition, the conference materials, survey data and final report represent a tangible resource for those rural health and human service providers throughout the country seeking information about domestic violence and educational materials.

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*Health professionals include physicians, EMTs, paramedics, nurses, pharmacists, dentists, nurse practitioners, physician assistants, social workers, psychologists, mental health workers, nurses aides, health facilities administrators, etc.

Educating rural health care professionals in Texas has enabled them to realize the broad scope of domestic violence in rural Texas and helped them to become attuned to violence indicators. The health professionals were trained in the areas of violence assessment, evaluation and intervention. Rural health providers developed an increased awareness of their larger role as change agents in the community and at the same time became familiar with the network of existing domestic violence services. It is the conviction of the Rural Texas Domestic Violence Health Professionals Education Program that this type of educational opportunity will lead to the development of working relationships between rural health providers and domestic violence service providers, thus creating and/or expanding local services, strengthening the existing service network, enhancing public awareness, and helping to foster social change.

The health care needs of rural Texans who are victims of domestic violence can most effectively be met by providing services where none exist, improving health care delivery of existing programs, and creating new services which are specific to rural needs. By addressing the rural domestic violence problem through education of rural health providers, the health care needs of rural Texas victims can be better served.

The final report for the Rural Texas Domestic Violence Health Professionals Education Program will first discuss the domestic violence problem in rural Texas and the need for services, followed by discussions of the goals, program approach, and program activities. The next section will detail the analysis of data from the statewide survey and conference interviews. The final sections will focus on program evaluation, results and conclusions.

# THE PROBLEM

"...Those abused suffer in silence too often."[1]

Conflict is a fundamental, constructive aspect of social organization. Violence is its destructive extreme. The elements of violence and aggression in human relationships, whether manifested in spouse abuse, parent battering or abuse of the elderly, are more pervasive in family life than is often recognized. In fact, it would be hard to find another institution in society in which violence is more an everyday occurrence than it is within the family. Studies which bear witness to the violent American family reveal that as many as fifty-four percent of the families studied have violent interactions.[2] Domestic violence may well be the number one mental health problem in America today.

The romantic and harmonious image of the American family has been in part responsible for the long postponement in bringing the issue of family violence to public awareness. So strongly has the myth of the conflict-free family prevailed that it wasn't until the late 1960s that the issue of family violence was brought into focus. Briefly, the issue of domestic violence has come to public awareness as a part of the wave of concern demonstrated for violence in general. Dramatic increases in the incidence of rape, murder and inner city crime contribute to the image of the violent urban American society. But what about the rural American, and more specifically, the rural Texan?*

"...The general population feels these problems
only occur in large cities."[1]

---

*A rural Texan is a person living in a nonmetropolitan area of Texas. Nonmetropolitan is designated as all farms, open countryside, and places of less than 50,000 residents outside standard metropolitan statistical areas.

The myth exists that life in rural Texas is more serene, healthy and simple than the average complex urban Texas existence. In fact, the mental and physical health of rural Texans is much worse than that of urban Texans. If health is defined in terms of mental, physical, environmental and social factors, it is inaccurate to say that rural residents are receiving health care. Rural residents do have some access to medical care, but even this is often limited by isolation, poverty, lack of health insurance or coverage under public programs, cultural barriers, racial discrimination and limited education.

Rural communities are considered to be places where the air is clean, the sky is blue and the value systems are something to be envied. Yet statistics indicate that the accident rate is higher in rural areas and that rural residents experience more days of disability and more chronic illness than their urban counterparts. These can all be linked to the increased stress of rural life. In addition, statistical data indicate that rural communities experience drug abuse, child abuse, depression and teenage pregnancy just as frequently as do urban communities.[5]

Nowhere does the stress of rural life have greater impact than on the mental health of the family, where the dynamics of stress and frustration manifest themselves in increased levels of violence. Conflict and aggression are very much a part of the daily life of rural Texans.

> "...Domestic violence may be a way of life here,
> but generally it doesn't get out to the public."[1]

For rural Texans, women and children especially, the home may contain many socially hidden dangers, particularly when the complex phenomenon of violence is part of the family's interactions. The family is the most intimate group to which the majority of people belong. At its best, the family is an unrivalled source of strength and nurturance; however, this very closeness can also foster the worst in human relationships. Paradoxically, it is the intimate context of the rural family within the socially remote rural community that may offer one of the most conducive environments for growth of this type of dysfunctional relationship.

> "...We have seen very little of this in our E.R. and are generally hesitant in caring for those victims since we have little experience in this area."[1]

The problem is that Texas rural health care professionals lack knowledge and skills of assessment, intervention and evaluation of domestic violence victims. Most rural health care providers are not aware of the extent of rural domestic violence or the existence of any services for domestic violence victims. In addition, the scarcity of trained health care providers of all types, whether it is mental health workers, psychologists, physicians, nurses or social workers, further hampers the delivery of existing services to domestic violence victims.

The incidence of domestic violence in Texas has reached critical proportions. Findings from a survey on spouse abuse conducted by the Criminal Justice Center in 1982 reveal that more than 1,500,000 women currently living in Texas have been abused by their husbands or partners at some time in their lives, and that 317,000 of those women over the age of 18 were abused within the year before the survey was conducted. Twelve percent of those women abused within the previous year and 24% of those abused during their lifetime required medical treatment. Based on those findings it can be estimated that at least 358,595 women currently living in Texas have required medical treatment by a doctor or hospital because of abuse by a spouse or live-in partner. Seventeen percent of the women abused during the previous year and 33% of

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those abused during their lifetime had children who were also victimized by the abuser.[3]

Abuse of elderly persons is also a problem of significant magnitude in Texas, but one with much less documentation than either child or spouse abuse. However, 61% of respondents to a survey conducted by the Gray Panthers of Austin reported that they had encountered cases of elderly abuse in their work.[4]

## The Need for Service Delivery

> "...Rural victims and families usually want to keep the problem to themselves rather than seek counseling and risk exposure to the community."[1]

That domestic violence exists in rural Texas is recognized and accepted by all researchers into its incidence. Urban shelter projects are also aware of the extent of the problem but rural health providers are not. The rural health professional may be seeing families whose history or present behavior patterns suggest the potential for violence and yet fail to recognize the symptoms. In addition, the characteristics particular to rural family violence, such as greater isolation and fewer options, create unique problems of health care delivery.

Delivery of services to victims of domestic violence in rural Texas is hampered by population dispersion, lack of financial resources, inadequate specialized technical expertise, and few human service programs. This problem is further complicated by the utilization of urban models for delivery of those services. Rural population dispersion has increased since World War II when more and more rural Texans found themselves pulling up roots and moving into the major cities of our state. While Houston, Dallas-Fort Worth and San Antonio bloomed, much of rural Texas was experiencing major upheavals in its way of life. During the 70s this trend was reversed, resulting in a continuing increase in rural population. We now see rural Texas with an everdepleting tax base and an increasing inability to provide quality human services for its expanding population.

> "...Funds are needed to provide safe houses, legal aid, medical attention, food, clothing, job training, day care, etc., etc."[1]

Inadequate financing and poverty are major obstacles to the improvement and use of health care services in rural Texas. Related to this is the fact that 43% of the people living in nonmetropolitan Texas are under the age of 14 or over the age of 64, and it is the very young and very old who are the most impoverished and most often abused.[5]

> "...The rural areas always lack the funds to support the personnel and facilities providing the help and care needed to properly serve the violence victims."[1]

In addition, rural Texans cannot afford urban health services programs because they lack many conventional urban resources. However, rural Texans have other resources which stem from a strong sense of community, a self-help tradition and established helping networks. These valuable rural assets should be used in the organization of human services.

Many residents have sought their own way of refurbishing their towns. They have developed their own unique methods of providing day care centers, establishing youth recreation programs, and building libraries. Other communities have adjusted less well to the urban bias which now permeates Texas political and social policies. In such communities as this, the gap between those who have and those who don't is often great. Those who are more monetarily endowed find it easy enough to go outside the community for their needs, while many others--the poor and the elderly--must either go without services or accept those which are often of lesser quality.

As a result of these trends, most rural Texas communities have just skeletal human and health services, particularly in relation to domestic violence. Preliminary data from a 1980 Texas mental health needs assessment revealed that of the 338 rural Texans* responding to a question on the amount of unmet mental health needs for family violence and child abuse, 50% rated the problem as great or very great and only 7% perceived that there were no unmet needs. When asked about the adequacy of rural community mental health services for domestic violence and child abuse, 67% of the rural residents surveyed felt that services were inadequate. Further, 42% felt there were not enough services and 7% stated that there were no services at all.[6]

The domestic violence services and shelter programs throughout the state are primarily concentrated in urban areas and mainly focus on crisis intervention and housing for battered women and their children. Shelter locations and inadequate rural outreach programs force most eligible rural victims to abandon their communities and undermine attempts at community support and rehabilitation. In short, the options of rural victims of domestic violence are limited at best.

Rural health and social service delivery systems have added to the problem by being slow to respond to the needs of the victims and their families. This is largely due to the isolation and lack of awareness on the part of health providers, who usually have an inadequate understanding of the extent and dynamics of the violence. To further compound the problem, health providers lack a familiarity with available services, or have no available services, and have no working relationships with domestic violence service providers.

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*This number represents approximately 20% of the people surveyed and accurately reflects the rural percentage of Texas' population.

Another factor which has contributed to the lack of services to rural victims of domestic violence is the relatively short period of time that these services have been available. Shelter services to victims of domestic violence in Texas began in 1977 with the opening of the Austin Center for Battered Women.

Shelter services have increased over the last five years to include 34 shelters located throughout the state. During this period the scope of services and service networks has also expanded.

As a natural extension of the need to provide comprehensive domestic violence services throughout the state, the state shelter network organization, the Texas Council on Family Violence, has designated the education of health professionals and outreach to rural areas as two of its priorities. These new priorities seek to strengthen service delivery to rural victims through integrating primary preventative care and mental health services with the existing domestic violence service network.

## Educational Needs and Training Programs

Health care providers are in short supply in rural communities and most are overworked. There are very few specialists and most hospitals cannot afford social service departments. What, then, can be done to increase the availability of health care services to domestic violence victims?

An educational program must be mounted for rural health care professionals, enabling them to realize the broad scope of domestic violence in rural Texas and helping them to become attuned to violence indicators. The health professional needs training in the areas of violence assessment, evaluation and intervention. He must develop an understanding of the signs, symptoms, and conditions of the potentially or obviously violent situation.

Rural health providers need to develop an increased awareness of their larger role as change agents in the community. They are often look to for leadership, and leadership is desperately needed in promoting community awareness of the incidence and impact of domestic violence on community mental health as well as acquainting the community with existing services.

The few training programs and continuing education workshops on domestic violence designed for health care professionals are primarily focused on urban, hospital-based intervention and do not contain a community leadership or networking component. Guidelines providing recommendations on content for general purpose workshops usually contain many aspects of the problem which are pertinent to the understanding of all types of service providers. These include: (1) acquainting participants with the problem, (2) reviewing state law, (3) presenting the facts about shelters and services, and (4) presenting specific information on how to help. However, these programs are neither specific enough for health professionals nor geographically focused on the needs of rural Texas.

> "...The area we serve is a rural population and I feel it will be a hard target area to convince that they need help with the problems of abuse."[1]

Determining the local health care providers' attitudes about domestic violence and soliciting their input were necessary steps to successful training programs and networks. It is all too easy for urban professionals and domestic violence experts to be seen in the position of telling local providers what is needed. Therefore, educational and awareness programs in rural Texas must be designed with an understanding of a sensitivity to prevailing local norms and attitudes about the domestic violence problem. This education program represented an opportunity to develop both a major facet of the domestic violence treatment program, and link it with the chain of existing services and the public education effort of the Texas Council on Family Violence. Educating health and human service providers will give them the skills they need to deal effectively and efficiently with individual victims, educate other health/human service professionals, and provide a basis for community support. In addition, these enlightened health care professionals can provide the leadership for establishing more comprehensive local services throughout the state which will enhance public awareness and bring about social change.

# PROGRAM DESIGN

This section will detail the design of the Rural Texas Domestic Violence Health Professionals Education Program. The goals, approach and purpose are presented. This is followed by a brief overview of the program and a specific discussion of activities by objective.

## Goals of the Rural Texas Domestic Violence Health Professionals Education Program

The long-term goal of the Rural Texas Domestic Violence Health Professionals Education Program was to facilitate the delivery of economical, coordinated and comprehensive health care to rural Texans seeking alternatives to an abusive family situation through the development of community oriented rural health service networks. The immediate goal of the Rural Texas Domestic Violence Health Professionals Education Program was to provide rural health care professionals with the knowledge and skills to identify domestic violence victims, utilize existing services and resources, coordinate existing service, create needed services, and design local networks.

These health professionals and community health care services will become part of the existing network of domestic violence services of the Texas Council on Family Violence. Further, it was expected that the program would heighten public awareness and increase public education throughout the state, which would foster a preventative and supportive environment for domestic violence treatment.

## Program Approach

The health care needs of rural Texans who are victims of domestic violence can most effectively be met by providing services where none exist, improving health care delivery of existing programs and creating new services which are specific to rural needs.

The approach used by the Texas Rural Health Field Services Program was designed to:

1. Use existing resources and local health care providers to meet the needs of domestic violence victims
2. Respond to the individual needs of regions and particular communities
3. Provide tools to design programs to deal with specific rural health care delivery weaknesses
4. Provide a model for replication by other states
5. Develop an educational materials package

The purpose of the Rural Texas Domestic Violence Health Professionals Education Program was to train health professionals in rural areas to:

1. Assess and intervene with domestic violence victims
2. Discuss available resources and referral agencies
3. Identify community health resources
4. Identify community health service weaknesses
5. Report violence to local law enforcement
6. Link local rural health service providers and other domestic violence service providers
7. Train other local health care providers to develop volunteer oriented human service networks.

The Rural Texas Domestic Violence Health Professionals Education Program was divided into four phases and took fourteen months to complete. All phases of the educational program were coordinated with the Texas Council on Family Violence.

Phase One took three months and involved the identification of the education program participants. This included identifying rural health care providers, health care agencies and other interested individuals. A mailing list was developed and the identified rural health providers were notified of the conferences.

Phase Two took six months and consisted of developing a regional breakdown for the conference to provide for culturally and geographically individualized conference formats. This phase included the design, administration and evaluation of a survey to determine cultural and geographic regional boundaries. In addition, the conferences' format and contents were developed.

In Phase Three, five free conferences were given throughout the state. This phase included the steps associated with a conference presentation, such as facility identification, conference publicity, presentation and evaluation of each conference.

The last phase, two months in duration, involved the analysis of the survey, interview and evaluation data, completion of the final report and dissemination of the report, followed by the transfer of program materials to the Texas Council on Family Violence.

The end products of the program consist of knowledgeable rural health professionals, the domestic violence resource guide, the conference training package, and the final report of the Rural Texas Domestic Violence Health Professionals Education Program.

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## PHASE I: IDENTIFICATION OF EDUCATION PROGRAM PARTICIPANTS

On June 10, 1982 the Texas Rural Health Field Services Program received approval for support of the Rural Texas Domestic Violence Health Professionals Education Program (RTDVHPEP) from the Hogg Foundation. Organizing meetings were held. Utilizing the Program Work Plan task plans were developed. A summary of activities which were carried out to fulfill each phase of the program will be discussed by objective.

### Objective I: Identify rural health providers, health care agencies, and interested individuals.

An initial mailing list of approximately 600 health/human services agencies, organizations and individuals was developed. This included state agencies, professionals organizations, certifying boards, all shelter programs, community agencies, churches, and individuals.

Identification of rural health providers proved more difficult than was initially expected due to the inavailability of agency and organizational lists on a metro-nonmetro basis and tight money situations, which prohibited computer runs of membership lists to pull only rural providers. However, a comprehensive list of over 27,000 rural health providers was compiled for use with the survey and conference publicity.

### Objective II: Notify professionals, shelters, and those others identified of the education program.

Letters were sent to 202 agencies and organizations, over 200 persons interested in rural Texas and the 35 shelter programs, informing them of the Rural Texas Domestic Violence Health Professionals Education Program and its goals. They were asked for their help in the identification of prospective program participants. A program overview was written and accompanied the letter.

## Objective III: Coordinate program with Texas Council on Family Violence.

Coordinating meetings were held at strategic times throughout the duration of the project with Texas Council on Family Violence rural liaison Gail McIntosh and executive associate Debby Tucker. The meetings were conducted to detail the specifics of the collaboration between the Council and the program during all phases of the project.

The annual meeting of the Texas Council on Family Violence was held on October 16 in Port Aransas, Texas. Karen Mountain attended the conference. A report on the Rural Texas Domestic Violence Health Professionals Education Program was presented to the general membership and a request was made for input on the conference design and content from council members.

## PHASE II: DESIGN CONFERENCE

### Objective I: Design a survey to aid in specific geographic and cultural foci for individual conferences.

The first draft of the survey instrument was completed during the second week in October. Twelve people with expertise in one or more areas including survey design, domestic violence, health care, and rural health were selected to pilot test and critique the survey instrument. The final survey questionnaire (Appendix A) reflects a composite of their comments and suggestions.

### Objective II: Select sample.

The sample population was selected utilizing the following procedure. First every name on the participant list was coded by region and by category to insure a geographic and professional distribution for the sample selection. A total sample of 2,520 was selected. This sample population was designed to approximate 8-10% of the projected total number of prospective participants. The time constraints of Phase II, coupled with the continuing arrival of new lists, necessitated the use of figure projections and an incomplete list. Sixty individuals from each professional category in each region were randomly selected, except in categories such as hospitals in west Texas which did not contain 60 or more names. The total sample population at the time of mailing was 2,241. The adjusted sample population of 2,217 reflects those surveys returned due to change of address, retirement or death. Using the adjusted sample population figure of 2,217, 8% of the total number of prospective participants were sampled.

### Objective III: Administer survey.

Survey questionnaires were sent to 2,241 rural health professionals during the last week in November. The cover letter described the purpose of the survey and requested that the completed questionnaires be returned by December 17. Few questionnaires were received by the deadline and responses continued to flow in until the first week in January. A total of 326 surveys, or 14.3%, were received by January 12. A reminder postcard was sent to the adjusted sample population (2,217) during the second week in January. A total of 454 questionnaires, or 20% of those sent, had been received as of February 7, 1983. The final number of survey respondents totalled 479, or 22%, of those surveyed.

### Objective IV: Evaluation of survey.

Data coding procedures were developed and the Texas Rural Health Field Services Program staff began coding data during the first week in February. An SPSS dummy file was set up with the help of the Research Center at the University of Texas School of Nursing. Frequency data was run and then examined for significant findings. Parts of the data were further analyzed using chi-square and analysis of variance. Survey findings will be detailed in the section entitled Data Analysis.

### Objective V: Identify regions and contact persons and shelters in each region.

Differences on the basis of geographic and cultural data obtained in the survey failed to indicate specific regions which differed from those selected for use in administering the survey. Therefore, the original six regions were used in conference development.

A map detailing the regional breakdown was sent to Gail McIntosh during the first week in January. The Texas Council on Family Violence agreed to delineate the shelters in each region and provide a shelter contact person in each region.

## Objective VI: Design conference.

Input on conference design was solicited from rural communities, the Gray Panthers, the Regional Center on Child Abuse and the shelters at the annual meeting of the Texas Council on Family Violence. In addition, there were several questions on the survey whose purpose was to identify educational needs.

The method for the development of specific conference content was revised to reflect the suggestions and concerns of a sample of communities which were interested in hosting conferences. Meetings were held with shelter representatives and health professionals in Alpine, Victoria and Coldspring and additional input was received on conference content and format. The concensus was that the content needed to be flexible enough to meet the varying needs of each region and to allow local experts to participate as speakers.

It was therefore felt that the conference content format should be revised and developed in the form of objectives, guidelines and resources to provide continuity among conferences and yet allow individual experts to develop their own presentations.

Literature in the following content areas was collected and synthesized to produce conference development guidelines (Appendix B):

--general information on abused children, women, men, and the elderly

--problem identification

--specific needs and problems of victims

--statewide resources

--legal and law enforcement issues

--community assessment

--service delivery problems in rural areas

### Objective VII: Evaluate conference design.

The conference design and conference development guidelines were critiqued by two members of the Texas Council on Family Violence, rural liaison Gail McIntosh and Coordinator of Research and Education Melissa Eddy. Comments were also provided by Senate Human Resources Committee staff persons Leslie Lemmon, who worked on the interim study on domestic violence, health educator Emily Untermeyer, and Carolyn Gilmore from the Continuing Education department of the University of Texas School of Nursing.

A conference for faculty, students and area nurses was presented at Mary Hardin Baylor University School of Nursing on April 9, 1983 to pilot test some of the conference information and materials.

### Objective VIII: Revise conference design.

All comments were very favorable and no substantive changes were made in the conference development guidelines.

### Objective IX: Obtain continuing education credits for conference programs.

Continuing education credits were obtained for the majority of the expected conference participants, including physicians, R.N.s, L.V.N.s, social workers, E.M.T.s, and paramedics. The Lubbock conference was also approved for continuing education credits for law enforcement officers.

## PHASE III: CONFERENCE PRESENTATION

### Objective I: Locate facilities and speakers through regional contact people.

Initial contact was made with a shelter or domestic violence service group in each of the regions. In three regions contacts were made with groups which had made earlier requests for technical assistance on education and training of health providers. Each location was selected on the basis of the willingness of the domestic violence service group to co-sponsor a conference and the availability of conference facilities, motels and restaurants. Each facility needed to contain one area large enough to accommodate 150 people for the general sessions in the morning and at least three smaller areas for the afternoon workshops and films.

The conference sites selected were as follows and one or more pre-conference visits were made to each site.

Region 1: Sul Ross State University, Alpine, Texas
Region 2: Texas Tech University Health Sciences Center, Lubbock, Texas
Region 3: Victoria College, Victoria, Texas
Region 5: Stephen F. Austin State University, Nacogdoches, Texas
Region 6: Cooke County College, Gainesville, Texas

The conference for region 4 was not developed using the same format as the other regions due to the availability of other educational offerings in the area. Technical assistance and/or speakers were provided to Mary Hardin Baylor University School of Nursing for their conference on family violence and to the community services and medical education divisions of Fort Hood for their series of conferences on domestic violence. The Texas Council on Family Violence was provided a complete list of mailing labels of rural health providers in region 4 to include in their mailout for their annual conference.

Speakers for each conference consisted of physicians, nurses, attorneys, law enforcement officers, staff from the Texas Department of Human Resources, women's shelter directors, and members of the Texas Council on Family

Violence. Speakers were initially contacted by phone and then sent confirmation letters with conference development guidelines, conference brochures, and a program overview. Reference articles and bibliographies were supplied to each speaker upon request. Technical assistance on presentation content was given to many speakers.

The Rural Texas Domestic Violence Health Professionals Education Program staff recognized the need to develop a variety of local expertise in different areas of domestic violence services in order to provide each region with an ongoing source of education after completion of the program. Based on this premise, regional expertise was developed and utilized whenever possible.

## Objective II: Publicize conferences.

The brochure for the Lubbock, Victoria, Nacogdoches, and Gainesville conferences was designed in a generic form to be used by each conference. The brochure used in the Alpine conference was specific to that event. Use of the generic brochure eliminated lengthy printing delays and reduced the cost and time involved for brochure design and mailout.

News releases using general information from the program overview and specific conference information were provided to all area newspapers and television stations.

Letters were sent to each Texas Council on Family Violence shelter program informing them of the conference and requesting their participation. Gail McIntosh, rural liaison from Texas Council on Family Violence, called each shelter director to request that they make available any printed materials or media that they might have for conference use.

The Texas Department of Human Resources, the Texas Medical Association, the Texas Nurses Association and the State Department of Emergency Medical

Services were contacted with information on each conference for use in their publications.

Television interviews by one or more local stations took place at all conferences except Alpine. In addition, a Victoria television station produced a series of short documentaries on different facets of family violence which ran throughout the week of the conference.

## Objective III: Development of resource list and other conference materials.

Materials for each conference packet were designed to augment and reinforce the information provided during the conference. Each packet contained the following:

--A Rural Texas Domestic Violence Health Professionals Education Program overview
--Brochure on mandatory reporting of elderly abuse
--Texas Department of Human Resources Texas Shelter Directory
--Domestic Violence Referral and Resource List
--Conference Evaluation Form (Appendix C)
--A Bibliography of Relevant Reading Materials

## Objective IV: Give conferences.

On April 29 the first conference for health care professionals was held in Alpine, Texas. The conference was co-sponsored by the Women's Center and Sul Ross State University, both of Alpine. Thirty-nine individuals pre-registered for the conference. Registered attendance was seventy-two; however, actual attendance was closer to 90 due to the fact that many people attended only the afternoon sessions and did not sign up. The emphasis of this particular conference was on program development, crisis intervention (diagnosis and counseling), and shelter services.

On June 24 the second conference for health care professionals was held in Gainesville, Texas. The conference was co-sponsored by Cooke County Friends of the Family and Cooke County College, both located in Gainesville. Ninety-two individuals pre-registered for the conference; however 136 were actually in attendance. This was a fifty-three percent increase over the first conference. The emphasis of this conference was on the medical aspects of domestic violence, sexual abuse and family violence, and the abuser.

The third conference, held on June 15 in Victoria at The Victoria College, was co-sponsored by the Women's Crisis Center of Victoria and The Victoria College. One hundred and thirty-eight participants pre-registered for this conference and 188 were in attendance. The conference focus included community assessment, foundation funding and information on batterers.

The Lubbock conference, fourth in the series, was held on August 6 at Texas Tech University Health Sciences Center. The co-sponsors included Texas Tech University School of Nursing and Women's Protective Services of Lubbock. Sixty-one pre-registrations were received and 67 people were recorded in attendance; however, the conference rooms were spread out and maintaining an accurate sign-in was difficult. This conference had the most extensive workshop offerings during the afternoon. The focus was on legal issues, documentation and charting.

The final conference was held in Nacogdoches on September 16. The conference was co-sponsored by Stephen F. Austin State University Division of Nursing and the Women's Crisis Center of East Texas. Ninety-three participants pre-registered and 158 attended the conference. The focus included empathizing with victims and available resources and referrals in the east Texas area.

In all, 612 health and human service providers participated in the conferences. The largest conference was held in Victoria and the smallest in Lubbock.

## Objective V: Interviews with rural health and domestic violence service providers.

The domestic violence interview form (Appendix D) was created to validate and add to survey data. Five health/human services professionals were randomly selected for personal interviews at each conference by Project Coordinator Karen Mountain, R.N., M.S.N. Interview results are discussed in the evaluation section.

## Objective VI: Evaluation of each conference.

Conference evaluations were summarized and reports sent to each co-sponsor. The evaluations served as a basis for topic revisions.

A follow-up evaluation (Appendix E) was designed to gain data on how the new information and skills were being utilized and how well each conference had met the participant's needs. The follow-up evaluation was mailed one month after each conference, and a total of 66 follow-up evaluations were returned. Data was analyzed to provide frequency information and some cross tabulations were done.

## PHASE VI: DATA ANALYSIS AND PROGRAM EVALUATION

### Objective I: Analyze data from Rural Texas Domestic Violence Health Professionals Education Program survey and interviews.

Computer analysis was done on the survey data and conference interviews using the SPSS program. All surveys were numbered and a data coding method was set up. Computer programs for data analysis were set up for the surveys and frequency data was run on a statewide basis.

In order to obtain data for specific regions of the state and to be able to compare and contrast that data, the state was divided into six regions and the data were run on a regional basis. Some data were also run by professional category. To elicit differences in attitudes, educational needs, service delivery priorities and obstacles by profession or by region, chi-squares and analysis of variance were used on some of the data. A content analysis was performed on all the comments.

### Objective II: Evaluate the Rural Texas Domestic Violence Health Professionals Education Program.

Summaries were made of all the participant evaluations for each conference. Discussion of the participant evaluations appears in the evaluation section of this report.

Written evaluations were requested from the Program Director of the Texas Rural Health Field Services Program and from the rural liaison of the Texas Council on Family Violence.

### Objective III: Submit final report.

A draft of the final report was submitted to the Hogg Foundation for comments during the first week in October. The final revisions were made during the month of October and the final report was printed and disseminated to interested persons by November 30, 1983.

### Objective IV: Transfer materials to Texas Council on Family Violence.

All pertinent materials and a final report of the Rural Texas Domestic Violence Health Professionals Education Program will be turned over to the Texas Council on Family Violence during their November board meeting.

The following section will examine the attitudes, knowledge and priorities for services of two sample of rural health and human services providers. Data from both the survey and the conference interviews will be discussed.

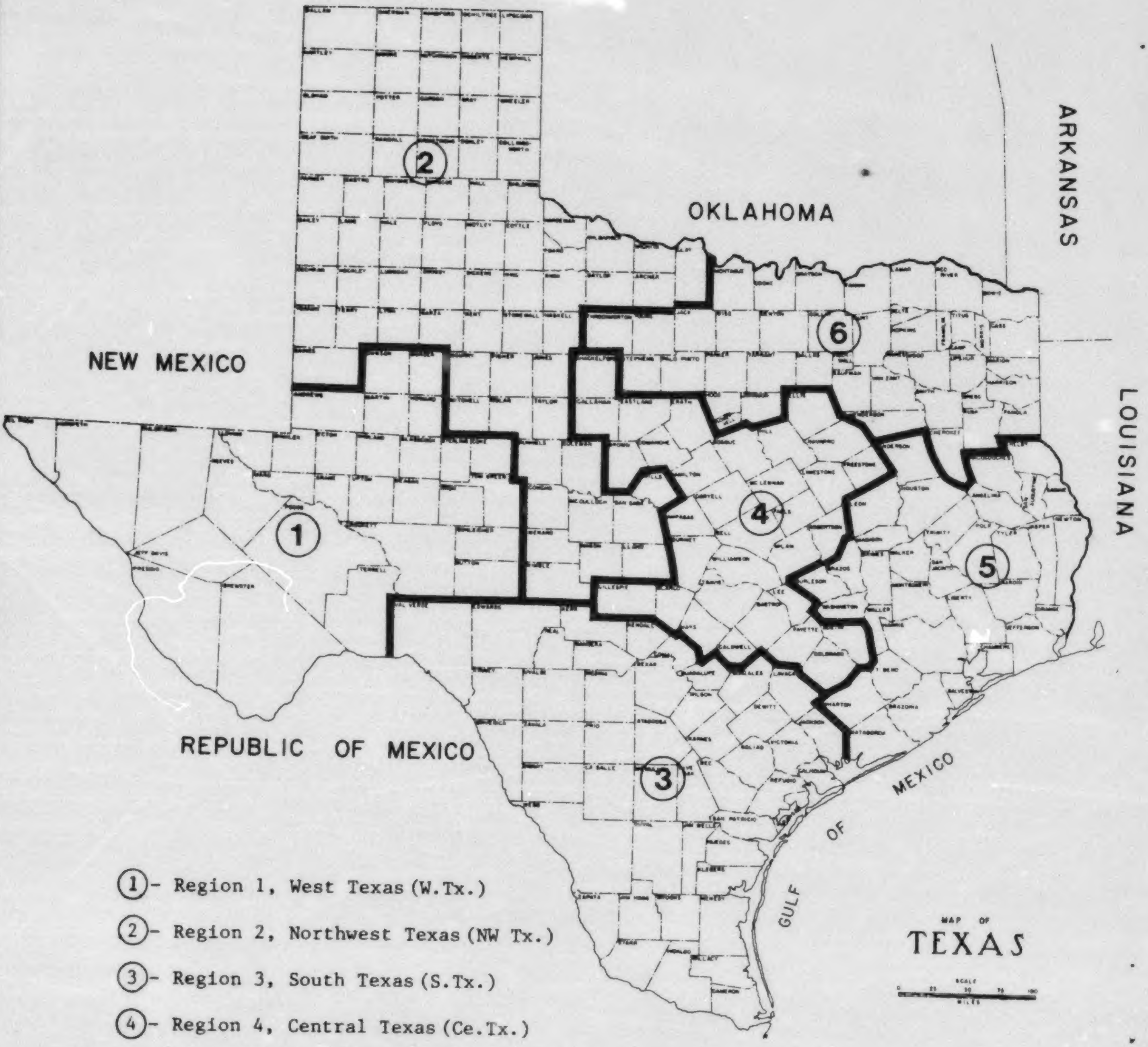
# DATA ANALYSIS

The following section contains the analysis of the Rural Texas Domestic Violence Health Professionals Education Program survey and the Domestic Violence and Rural Texas conference interviews. Survey data collection procedures and results will be discussed first, followed by data collection procedures and analysis of the interview data.

## Survey Data Collection Procedures

The sample population of 2,520 was selected for the survey from the 27,559 name list of rural health/human service providers. The entire participant list was coded by region and by professional category to insure a geographic and professional distribution for sample selection. This sample population was designed to approximate 8-10% of the projected total number of names on the list of rural health/human service providers. Sixty individuals from each professional and region category were randomly selected, except in categories such as hospitals in region 1 (west Texas) which did not contain 60 names. The total sample population at the time of mailing was 2,241. The adjusted sample population of 2,217 reflects those surveys returned due to change of address, retirement, or death. Using the adjusted population figure of 2,217, 8% of the total number of rural providers on the list were sampled.

A total of 479 surveys, or 22% of those sent, were filled out and returned in a usable form. The statewide frequency data was run using 479 subjects except in cases where there were missing responses. The state was divided into six regions (Map 1) so the data could be analyzed on a regional basis, using a total of only 404 respondents because not all the health/human service providers who returned surveys indicated which counties they served. When respondents reported serving counties in more than one region, they were


OKLAHOMA
ARKANSAS
NEW MEXICO
LOUISIANA
REPUBLIC OF MEXICO
GULF OF MEXICO
1
2
3
4
5
6
MAP OF
TEXAS
SCALE
0 25 50 75 100
MILES

①- Region 1, West Texas (W.Tx.)

②- Region 2, Northwest Texas (NW Tx.)

③- Region 3, South Texas (S.Tx.)

④- Region 4, Central Texas (Ce.Tx.)

⑤- Region 5, East Texas (E.Tx.)

⑥- Region 6, Northeast Texas (NE Tx.)

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placed in the region in which they served the greatest number of counties. Those respondents who served equal numbers of counties in two or three regions were assigned to the smallest region they served to make each regional population more equal.

The professional categories were made mutually exclusive and the Other category was eliminated to prevent respondents from being in more than one category. Those subjects that reported double professions were dropped, except in cases where they checked a named professional category and the Other professional category. For those cases the respondent was placed in the named professional category.

Data analysis of the survey will be discussed on a questions by question basis. Statewide frequency data for each question is discussed first, followed by regional and/or other significant findings resulting from statistical analysis utilizing chi-square or analysis of variance tests.

## Survey Data

### Demographic Characteristics

#### Profession of Respondents

The professions of survey respondents were coded into nine categories (Table 1). The category nurse, nurse practitioner, physician assistant accounted for the largest number of respondents (N=99). In order of frequency, the other specific professions represented were: justice of the peace (N=89); physician (N=49); EMT, paramedic, ECA (N=33); clinic, child care facility and community center administrator (N=18); hospital administrator (N=24); social worker, psychologist, mental health worker, counselor (N=15); and clergy (N=6). Eighty-nine respondents were from "other" professions.

## TABLE 1

## PROFESSIONS OF SURVEY RESPONDENTS

| Profession | Number of Providers | Percentage* |
|---|---|---|
| Physician | 49 | 14.7 |
| Nurse, Nurse Practitioner, Physician Assistant | 99 | 29.7 |
| EMT, Paramedic, ECA | 33 | 9.9 |
| Social Worker, Psychologist, Mental Health Worker, Counselor | 15 | 4.5 |
| Hospital Administrator | 24 | 7.2 |
| Clinic, Child Care Facility and Community Center Administrators | 18 | 5.4 |
| Clergy | 6 | 1.8 |
| Justice of the Peace | 89 | 26.7 |
| Other | 89 | 19.7 |

* These add up to more than 100% because many respondents checked more than one profession.

The frequency of professionals responding differed from region to region (Table 2). However, the category "Nurse, nurse practitioner, physician assistant" remained the largest category in all but region 2, where more physicians responded.

## TABLE 2

## PROFESSIONS OF SURVEY RESPONDENTS BY REGION

| Profession | | Region | | | | | | Total |
|---|---|---|---|---|---|---|---|---|
| | | West Texas | Northwest Texas | South Texas | Central Texas | East Texas | Northeast Texas | |
| Physician | # | 7 | 10 | 12 | 11 | 5 | 4 | 49 |
| | % | 2.1 | 3.0 | 3.6 | 3.3 | 1.5 | 1.2 | 14.7 |
| Nurse, nurse practitioner, physician assistant | # | 11 | 7 | 26 | 22 | 21 | 12 | 99 |
| | % | 3.3 | 2.1 | 7.8 | 6.6 | 6.3 | 3.6 | 29.7 |
| EMT, paramedic, ECA | # | 7 | 10 | 3 | 6 | 2 | 5 | 33 |
| | % | 2.1 | 3.0 | 0.9 | 1.8 | 0.6 | 1.5 | 9.9 |
| Social worker, psychologist, mental health worker, counselor | # | 3 | 0 | 5 | 2 | 3 | 2 | 15 |
| | % | 0.9 | 0.0 | 1.5 | 0.6 | 0.9 | 0.6 | 4.5 |
| Hospital administrator | # | 3 | 4 | 7 | 3 | 3 | 4 | 24 |
| | % | 0.9 | 1.2 | 2.1 | 0.9 | 0.9 | 1.2 | 7.2 |
| Clinic, Child care facility and community center administrators | # | 3 | 3 | 3 | 5 | 4 | 0 | 18 |
| | % | 0.9 | 0.9 | 0.9 | 1.5 | 1.2 | 0.0 | 5.4 |
| Clergy | # | 0 | 1 | 1 | 1 | 1 | 2 | 6 |
| | % | 0.0 | 0.3 | 0.3 | 0.3 | 0.3 | 0.6 | 1.8 |
| Justice of the peace | # | 18 | 18 | 16 | 11 | 13 | 13 | 89 |
| | % | 5.4 | 5.4 | 4.8 | 3.3 | 3.9 | 3.9 | 26.7 |
| REGIONAL TOTAL | # | 52 | 53 | 73 | 61 | 52 | 42 | 333 |
| | % | 15.6 | 15.9 | 21.9 | 18.3 | 15.6 | 12.6 | 100.0 |

The total number of respondents used to determine the regional breakdown was 404. This number does not equal 100% of the survey respondents (N=479) because not all survey respondents designated the county or counties they served (Table 3). The greatest number of respondents came from region 3, south Texas (N=81); the fewest from region 6, north Texas (N=54).

TABLE 3

TOTAL RESPONDENTS TO SURVEY BY REGION

| | Region | | | | | | |
|---|---|---|---|---|---|---|---|
| | West Texas | Northwest Texas | South Texas | Central Texas | East Texas | Northeast Texas | Total |
| Respondents | 67 | 68 | 81 | 71 | 63 | 54 | 404 |

## Services Provided

Respondents provided health (N=306), social (N=101), legal (N=65), religious (N=44), and other (N=93) types of services in their community (Table 4). Many respondents provided more than one type of service, therefore the total number of responses exceeded the sample size of N=479.

TABLE 4

SERVICES PROVIDED BY RESPONDENTS TO SURVEY

| Services Provided | Number of Providers | Percentage* |
|---|---|---|
| Health Services | 306 | 63.9 |
| Legal Services | 65 | 13.6 |
| Social Services | 101 | 21.1 |
| Religious Services | 44 | 9.2 |
| Other | 93 | 19.4 |

* These add up to more than 100% because many respondents provided more than one service.

The data in Table 5 indicate that the majority of respondents were involved in three service areas, namely administration, direct patient care, and/or law enforcement. As noted earlier respondents may have selected more than one area when their professional duties crossed categories. The broad category "administration" may most likely have been selected jointly with one of the other duty categories.

TABLE 5

PROFESSIONAL DUTIES OF SURVEY RESPONDENTS

| Categories of professional duties | Number of professional duties | Percentage* |
|---|---|---|
| Case work (social/psychological) | 39 | 8.1 |
| Direct patient care (hospital, clinic) | 143 | 29.9 |
| Direct patient care (home) | 49 | 10.2 |
| Administration | 173 | 36.1 |
| Law enforcement | 96 | 20.0 |
| Other (specify) | 76 | 15.9 |

* These add up to more than 100% because many respondents had duties in more than one category.

## Population Size Served by Respondents

The population of the area in which respondents worked ranged from less than 1000 to over 50,000 (Table 6). The largest number of respondents (N=96) served an area with a population of 10,000 to 25,000, whereas the smallest number of respondents (N=31) served a population area of over 50,000. Sixty-two percent (N=292) of the respondents worked in communities with a population of 10,000 or less.

## TABLE 6

## POPULATION OF AREA IN WHICH SURVEY RESPONDENTS WORKED

| Population | Number of areas with each population category | Percentage |
|---|---|---|
| Less than 1,000 | 36 | 7.7 |
| 1,000 to 2,500 | 75 | 16.0 |
| 2,500 to 5,000 | 90 | 19.1 |
| 5,000 to 10,000 | 91 | 19.4 |
| 10,000 to 25,000 | 96 | 20.4 |
| 25,000 to 50,000 | 50 | 10.6 |
| Over 50,000 | 31 | 6.6 |

### Counties Served

Health and human service providers responding to the survey were given a list of Texas' 254 counties and asked to circle each county they served. Eighty-three percent of the respondents served between one and five counties. The largest number of counties served was 60, which were served by one respondent from west Texas.

A total of 37 counties, or 14.5% of all the counties, were not served by any of the respondents. Twenty-two of these counties, or 59.5% of all the counties not served by any respondents, were nonmetropolitan. However, this represents only 8.7% of the total number of Texas counties and 11% of nonmetropolitan counties.

### Economic/Population Base of Area Served

Agriculture and ranching represented the predominant economic basis of the areas in which respondents worked (Table 7), except in region 5 where industry replaced ranching as the second most predominant economic base (Table 8).

## TABLE 7

## MAJOR ECONOMIC BASE OF AREAS IN WHICH SURVEY RESPONDENTS WORK

| Type of Economic Base | Number of Areas with each Type of Economic Base | Percentage* |
|---|---|---|
| Agriculture | 266 | 55.9 |
| Ranching | 223 | 46.8 |
| Industry | 119 | 25.0 |
| Mining | 19 | 4.0 |
| Other | 121 | 25.5 |

* These add up to more than 100% because many areas had more than one major economic base.

## TABLE 8

## MAJOR ECONOMIC BASE OF REGIONS IN WHICH SURVEY RESPONDENTS WORK

| | | Region | | | | | |
|---|---|---|---|---|---|---|---|
| Type of Economic Base | | West Texas | Northwest Texas | South Texas | Central Texas | East Texas | Northeast Texas |
| Agriculture | # | 19 | 55 | 52 | 45 | 29 | 28 |
| | % | 28.3 | 80.9 | 64.2 | 55.6 | 46.0 | 51.9 |
| Ranching | # | 33 | 34 | 50 | 36 | 18 | 22 |
| | % | 49.3 | 50.0 | 61.7 | 50.7 | 28.6 | 40.7 |
| Industry | # | 15 | 8 | 15 | 13 | 27 | 19 |
| | % | 22.4 | 11.8 | 18.5 | 18.3 | 42.9 | 35.2 |
| Mining | # | 3 | 3 | 3 | 4 | 1 | 4 |
| | % | 4.5 | 4.4 | 3.7 | 5.6 | 2.0 | 7.0 |
| Other | # | 32 | 14 | 17 | 9 | 14 | 15 |
| | % | 47.8 | 20.6 | 21.0 | 12.7 | 22.2 | 27.8 |

The majority of respondents (N=257) felt that there had been no major changes in the population or economic base of their service area. However, a large number (N=209) indicated that major changes had occurred (Table 9). Respondents who answered yes were asked to specify what type of economic or population change had occurred. Types of changes included population growth, factory openings and shutdowns, influx of unskilled labor, layoffs, oil booms, oil shutdowns, production cutbacks, influx of retirees and increased unemployment.

TABLE 9

MAJOR CHANGES IN POPULATION OR ECONOMIC BASE OF SERVICE POPULATION DURING LAST FOUR YEARS

| Respondent's answer | Number of answers | Percentage |
|---|---|---|
| Yes | 209 | 44.8 |
| No | 257 | 55.2 |

The thirteen specific categories were first developed and then collapsed into the six general categories reported in Table 10. Respondents from regions 1 and 2 perceived the primary type of change as the influx of labor. In region 3, industrial production increases were reported as the major change, whereas regions 4, 5 and 6 cited the major change as industrial production cutbacks. The conflict in results between the region reporting industrial production increases and the regions reporting cutbacks might be due to the fact that the economic base is made up of different industries.

TABLE 10

TYPE OF ECONOMIC CHANGE BY REGION

| Type of Change | | Region | | | | | | State Total |
|---|---|---|---|---|---|---|---|---|
| | | W.Tx. | NW Tx. | S.Tx. | Ce.Tx. | E.Tx. | NE Tx. | |
| Increased unemployment | # | 1 | 3 | 5 | 1 | 4 | 6 | 20 |
| | % | 0.5 | 1.4 | 2.4 | 0.5 | 1.9 | 2.9 | 9.5 |
| Population growth | # | 0 | 2 | 2 | 2 | 2 | 4 | 12 |
| | % | 0.0 | 1.0 | 1.0 | 1.0 | 1.0 | 1.9 | 5.7 |
| Influx of labor | # | 14 | 8 | 9 | 9 | 3 | 8 | 51 |
| | % | 6.7 | 3.8 | 4.3 | 4.3 | 1.4 | 3.8 | 24.3 |
| Industrial production cutback | # | 6 | 5 | 8 | 12 | 12 | 14 | 57 |
| | % | 2.9 | 2.4 | 3.8 | 5.7 | 5.7 | 6.7 | 7.1 |
| Industrial production increase | # | 7 | 2 | 10 | 7 | 8 | 7 | 41 |
| | % | 3.3 | 1.0 | 4.8 | 3.3 | 3.8 | 3.3 | 19.5 |
| Other | # | 1 | 4 | 8 | 4 | 8 | 4 | 29 |
| | % | 0.5 | 1.9 | 3.8 | 1.9 | 3.8 | 1.9 | 13.8 |
| REGIONAL TOTAL | # | 29 | 24 | 42 | 35 | 37 | 43 | 210 |
| | % | 13.8 | 11.4 | 20.0 | 16.7 | 17.6 | 20.5 | 100.0 |

Cells are not independent of one another.

Changes in the population or economic base of the area served were perceived as a factor in increasing the amount of domestic violence (Table 11). This exemplifies the fact that change, whether positive (industrial production increases) or negative (industrial production cutbacks) is stressful and increased stress leads to increased violence.

TABLE 11

CHANGES IN LEVEL OF DOMESTIC VIOLENCE DUE TO POPULATION OR ECONOMIC BASE CHANGE OF SERVICE POPULATION

| Type of Change | Number of responses | Percentage |
|---|---|---|
| Increase in domestic violence | 140 | 91.5 |
| Decrease in domestic violence | 13 | 8.5 |

Cultural/Ethnic Composition of Service Population

The data in Table 12 show the ethnic composition of the respondents' service population in relation to frequency served. Anglos were the most frequently served, followed by Mexican Americans, Blacks, Orientals, and others.

TABLE 12

CULTURAL/ETHNIC COMPOSITION OF SERVICE POPULATION

| Cultural/Ethnic Group | Most Frequently Served | | Frequently Served | | Not Frequently Served | | Least Frequently Served | |
|---|---|---|---|---|---|---|---|---|
| | No. | % | No. | % | No. | % | No. | % |
| Anglo | 330 | 76.2 | 69 | 15.9 | 25 | 5.8 | 9 | 2.1 |
| Black | 53 | 13.8 | 133 | 34.7 | 140 | 36.6 | 57 | 14.9 |
| Mexican American | 130 | 31.1 | 145 | 34.7 | 118 | 28.2 | 25 | 6.0 |
| Oriental | 6 | 2.2 | 2 | .7 | 21 | 7.6 | 246 | 89.1 |
| Other | 4 | 16.0 | 2 | 8.0 | 2 | 8.0 | 17 | 68.0 |

Religious Affiliation of Service Population

Health and human service providers were asked to describe the religious affiliation of their service populations, indicating a "1" beside the religious affiliation category most frequently served and a "7" beside the category least frequently served. However, including the religious affiliation category designated as "other" there were a total of eight categories in the questionnaire. Due to this oversight, the data from the question is incomplete and will not be reported.

## Domestic Violence

This section will present the respondents' perception of their community's attitude toward domestic violence, obstacles to comprehensive domestic violence services, quality of referral services and priorities of service needs.

### Perceived Attitudes of Community Toward Dealing with Domestic Violence

Respondents were asked for their perception of their community's level of awareness and attitude toward dealing with domestic violence.

When levels of perceived community awareness were analyzed on a profession by profession basis, the only significant differences were found between hospital administrators and justices of the peace. Hospital administrators (M=2.61) reported that their communities were significantly less aware of the problem of domestic violence than justices of the peace (M=3.25). This may be due to the fact that of all the professional categories of respondents the category "Hospital administrator" is least likely to be involved in direct patient care and more likely to be isolated from the community's attitude toward issues such as domestic violence than are justices of the peace (Table 13).

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TABLE 13

LEVEL OF PERCEIVED COMMUNITY AWARENESS BY PROFESSION

| Profession | Group Number | Level of Perceived Community Awareness | |
|---|---|---|---|
| | | Mean | Standard Deviation |
| Physician | 55 | 3.20 | .89 |
| Nurse, nurse practitioner, physician assistant | 125 | 2.98 | .97 |
| EMT, paramedic, ECA | 33 | 2.94 | 1.12 |
| Social worker, psychologist, mental health worker, counselor | 22 | 3.18 | 1.05 |
| Hospital administrator | 27 | 3.26 | .90 |
| Clinic administrator, community center administrator, child care facility administrator | 28 | 3.04 | 1.00 |
| Clergy | 5 | 3.20 | .84 |
| Justice of the Peace | 93 | 2.61 | 1.11 |
| F = 2.582 p = .013 | 388 | $M_G$=2.96 | $SD_G$ = 1.01 |

Over one quarter (26.5%) of the respondents perceived that there was positive support from individuals, government, business and law enforcement. However, the majority (34.8%) of respondents indicated that those who are aware (of domestic violence issues) are supportive. It appears that community awareness may be an important component of or prerequisite to community support in dealing with domestic violence. Mixed support mostly from individuals was reported by 17.4 percent of the respondents. A slightly larger percentage (17.8%) of respondents indicated indifference on the part of the community. Less than 4 percent of the respondents perceived negative community reactions/attitudes toward dealing with domestic violence (Table 14). Overall, it appears that there is positive support, in varying degrees, toward dealing with domestic violence.

TABLE 14

RESPONDENTS' PERCEPTION OF COMMUNITY'S ATTITUDE TOWARD DEALING WITH DOMESTIC VIOLENCE

| Perception of community's attitude | Number of responses | Percentage |
|---|---|---|
| Positive/support from individuals, government, business, law enforcement | 123 | 26.5 |
| Mixed/support mostly from individuals | 81 | 17.4 |
| Those who are aware are supportive | 162 | 34.8 |
| Indifference on the part of the community | 83 | 17.8 |
| Negative reaction/view problem as political/feminist issue | 2 | 0.4 |
| Negative reaction from churches/pro family groups | 1 | 0.2 |
| Negative attitude toward help from agencies and outsiders | 12 | 2.6 |

When analyzing the respondents' perception of their community's attitude toward dealing with domestic violence, coupled with their perception of their community's awareness of the problem (Table 15), the indication is that respondents who felt their communities were positive and supportive perceived their communities as being very aware of the problem. Those respondents who reported that their communities were less supportive also reported that their communities were less aware. The health and human service providers who perceived indifference on the part of their communities in dealing with domestic violence also saw their communities as not very aware of the problem.

## TABLE 15

## PERCEPTION OF COMMUNITY'S ATTITUDE VS. PERCEPTION OF COMMUNITY'S AWARENESS OF DOMESTIC VIOLENCE

| Community's Attitude | Group Number | Perception of Community's Level of Awareness of Domestic Violence | |
|---|---|---|---|
| | | Mean | Standard Deviation |
| Positive/support from individuals, government, business, and law enforcement | 123 | 2.195 | .997 |
| Mixed support/mostly from individuals | 80 | 2.838 | .803 |
| Those who are aware are supportive | 162 | 3.124 | .869 |
| Indifference on the part of the community | 83 | 3.590 | .924 |
| Negative attitude | 15 | 3.333 | .724 |
| F = 34.473 p = 0 | 463 | $M_G$=2.918 | $SD_G$ = .9002 |

Viewing the perception of a community's attitude toward dealing with domestic violence on a region by region basis revealed some interesting findings. More health/human services professionals than expected from region 1 (west Texas) felt that their communities received positive support in dealing with domestic violence. The negative attitudes reported among respondents from region 5 (east Texas) were greater than the statistical expectation. Reports of indifference from region 6 (northeast Texas) were also greater than expected (Table 16).

TABLE 16

RESPONDENTS' PERCEPTION OF COMMUNITY'S ATTITUDE
TOWARD DEALING WITH DOMESTIC VIOLENCE BY REGIONS

| Category | | Region | | | | | |
|---|---|---|---|---|---|---|---|
| | | W.Tx. | NW Tx. | S.Tx. | Ce.Tx. | E.Tx. | NE Tx |
| Positive/support from individuals, government, business, law enforcement | # | 26 | 17 | 19 | 14 | 17 | 11 |
| | % | 6.6 | 4.3 | 3.1 | 3.6 | 4.3 | 2.8 |
| Mixed/support mostly from individuals | # | 10 | 16 | 12 | 14 | 11 | 8 |
| | % | 2.6 | 4.1 | 3.1 | 3.6 | 2.8 | 2.0 |
| Those who are aware are supportive | # | 23 | 25 | 28 | 32 | 20 | 14 |
| | % | 5.9 | 6.1 | 7.1 | 8.2 | 5.1 | 3.6 |
| Indifference on the part of the community | # | 7 | 6 | 17 | 8 | 9 | 18 |
| | % | 1.8 | 1.5 | 4.3 | 2.0 | 2.3 | 4.6 |
| Negative attitude* | # | 1 | 0 | 3 | 1 | 4 | 1 |
| | % | 0.3 | 0.0 | 0.8 | 0.3 | 1.0 | 0.3 |
| REGIONAL TOTALS | # | 57 | 64 | 79 | 69 | 61 | 52 |
| | % | 17.1 | 16.3 | 20.2 | 17.6 | 15.6 | 13.3 |

*All negative response categories were collapsed into one category entitled negative attitude.

## Obstacles to Domestic Violence Services

The data in Table 17 summarize the obstacles to achieving comprehensive domestic violence services in rural areas. More in-depth information on how respondents rated each obstacle is available in Appendix F, Table 48. The five "greatest obstacles" are:

1. Lack of support or awareness by community
2. Lack of money/funds for personnel and materials
3. Other
4. Reluctance to report child abuse
5. Poor case reporting/case finding system

## TABLE 17
## SUMMARY OF OBSTACLES TO ACHIEVING COMPREHENSIVE DOMESTIC VIOLENCE SERVICES IN RURAL AREAS

| Obstacle | Rank | Mean |
|---|---|---|
| Lack of client transportation | 1 | 6.14 |
| Other | 2 | 5.82 |
| Lack of support or awareness of health professionals and agencies | 3 | 5.76 |
| Distance between your community and health, MHMR and shelter services | 4 | 5.33 |
| Negative attitudes such as beating is OK/don't pry | 5 | 4.85 |
| Cultural barriers | 6 | 4.75 |
| Lack of support or awareness by community | 7 | 4.25 |
| Reluctance to report child abuse | 8 | 4.13 |
| Poor case reporting/case finding systems | 9 | 4.08 |
| Lack of money/funds for personnel and materials | 10 | 3.85 |

Obstacle Rating Scale: "1" indicates the greatest obstacle, "10" indicates the least obstacle.

It should be noted that the data showed that respondents perceived their respective community to be generally supportive toward dealing with domestic violence. However, as noted above "lack of support or awareness by the community" was perceived as the greatest obstacle to achieving comprehensive domestic violence services. The five "least obstacles" are:

1. Other
2. Lack of client transportation
3. Distance between your community and health, MHMR, and shelter services

4. Lack of support or awareness of health professionals and agencies
5. Negative attitudes such as beating is OK/don't pry

Transportation and distance to services related to domestic violence are apparently not perceived as crucial barriers to achieving comprehensive domestic violence services. Additionally, negative attitudes toward domestic violence and professional/agency lack of support are perceived as minimal obstacles. One reason for these findings may be that professionals/agencies are supportive and that negative attitudes, such as beating is OK, are minimal in the community. Data in Table 14 presented earlier provide some support for the preceding explanation.

The data in Table 18 summarize the perceived obstacles to achieving comprehensive domestic violence services by region. A more detailed analysis of this information is available in Appendix F, Table 49. The perceived obstacles vary greatly from region to region. In regions 2 and 5 poor case reporting and case finding systems were reported as the greatest obstacle, while lack of money/funds or personnel and materials were viewed as the greatest problem in regions 3, 4 and 6. Respondents in region 1 identified the reluctance to report child abuse as the greatest obstacle.

## TABLE 18
## SUMMARY OF OBSTACLES TO ACHIEVING COMPREHENSIVE DOMESTIC VIOLENCE SERVICES BY REGION

| Obstacle | Region | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | West Texas | | Northwest Texas | | South Texas | | Central Texas | | East Texas | | Northeast Texas | |
| | M | R | M | R | M | R | M | R | M | R | M | R |
| Lack of client transportation | 7.57 | 9 | 6.38 | 8 | 6.00 | 8 | 5.75 | 9 | 5.17 | 9 | 5.80 | 8 |
| Distance between your community and health, MHMR and shelter services | 4.88 | 7 | 5.50 | 5.5 | 3.75 | 2 | 4.90 | 7 | 4.33 | 5 | 3.75 | 4 |
| Lack of support or awareness of health professionals and agencies | 6.57 | 8 | 7.00 | 9 | 8.14 | 9 | 3.80 | 3 | 5.00 | 8 | 4.83 | 5 |
| Lack of support or awareness by community | 4.86 | 6 | 6.00 | 7 | 5.63 | 7 | 4.22 | 4 | 4.17 | 4 | 3.13 | 2 |
| Negative attitudes such as beating is OK/ don't pry | 3.78 | 3 | 5.50 | 5.5 | 4.38 | 3 | 4.88 | 6 | 4.80 | 7 | 4.88 | 7 |
| Cultural barriers | 4.71 | 5 | 5.20 | 4 | 4.56 | 4 | 4.75 | 5 | 4.60 | 6 | 6.17 | 9 |
| Lack of money/ funds for personnel and materials | 4.63 | 2 | 5.00 | 3 | 3.45 | 1 | 2.00 | 1 | 3.60 | 3 | 1.75 | 1 |
| Poor case reporting/case finding systems | 3.13 | 2 | 3.75 | 1 | 5.00 | 5.5 | 3.67 | 2 | 2.57 | 1 | 4.86 | 6 |
| Reluctance to report child abuse | 2.20 | 1 | 3.88 | 2 | 5.00 | 5.5 | 5.25 | 8 | 3.50 | 2 | 3.70 | 3 |

Obstacle Rating Scale: "1" indicates the greatest obstacle, "10" indicates the least obstacle.

M = Mean
R = Rank

Health and human service providers answering the survey were queried as to their need for information and training which could improve their ability to serve rural domestic violence victims. The specific need categories are detailed in Table 19. General information was identified as most needed by 63% (N=230) of the respondents, while only 8.8% felt it was not needed at all. A total of 46.8% (N=159 and N=148) of those answering the question felt that counseling techniques and building community support were most needed. These facts indicate the need for educational programs which are both broad based and at the same time address specific issues in domestic violence service delivery.

TABLE 19

## RESPONDENTS' PERCEPTION OF INFORMATION AND TRAINING NEEDS TO IMPROVE SERVICE TO DOMESTIC VIOLENCE VICTIMS

| | Needs Rating Scale:<br>"1" indicates most needed;<br>"2" indicates somewhat needed;<br>"3" indicates not needed;<br>"4" indicates unknown | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | 1 | | 2 | | 3 | | 4 | |
| NEEDS | No. | % | No. | % | No. | % | No. | % |
| General information | 230 | 63.0 | 73 | 20.0 | 32 | 8.8 | 30 | 8.2 |
| Information on diagnosis & treatment | 102 | 33.0 | 114 | 36.9 | 46 | 14.9 | 47 | 15.2 |
| Counseling techniques | 159 | 46.8 | 88 | 25.9 | 47 | 13.8 | 46 | 13.5 |
| Building community support | 148 | 46.8 | 98 | 31.0 | 29 | 9.2 | 41 | 13.0 |
| Resources and referrals | 117 | 37.0 | 115 | 36.4 | 35 | 11.1 | 49 | 15.5 |
| How to start a shelter | 76 | 26.6 | 76 | 26.6 | 65 | 22.7 | 69 | 24.1 |
| Fundraising | 81 | 28.9 | 73 | 26.1 | 64 | 22.9 | 62 | 22.1 |
| Working with clients from other cultures | 64 | 21.9 | 89 | 30.5 | 65 | 22.3 | 74 | 25.3 |
| Solving geographic and transportation problems | 45 | 15.6 | 90 | 31.3 | 80 | 27.8 | 72 | 25.0 |

When each of the information and training need categories were analyzed on a region by region basis, several differences were found to be significant. Region 5 felt that information on building community support was more needed than in regions 1, 2 or 6. Region 5 also considered training on resources and referral agencies more imperative than did regions 1, 2 or 4. In addition, regions 4 and 5 felt information on fundraising was more needed than did regions 1 and 2. These regional differences point out the necessity to focus education and training to meet specific needs on a region by region basis.

All survey respondents were asked to indicate how many cases of each type of abuse were encountered during the last year. The greatest number of responses occurred in all of the 0-3 case categories. The greatest number of responses for the 3-5 case category was reported for women victims (18-64 years, N=55). The category women (18-64 years) also received the greatest number of responses in the 6-10 case and greater than 10 case categories (Table 20).

Case categories were inadvertently made overlapping. When the cases of abuse encountered during the last year were examined on a region by region basis it was found that there were no significant differences in number of cases between regions (Table 21). In addition, there were no significant regional differences among the various types of victims (Table 22). These findings support the contention that domestic violence is a widespread problem in Texas.

Of the significant tables--female victims, boy victims, and male victims--justices of the peace saw greater than 10 cases more frequently than any of the other professions. This may be due to the fact that justices of the peace provide one of the few resource options available to rural victims.

## TABLE 20

## CASES OF ABUSE ENCOUNTERED DURING THE LAST YEAR

| Victim | 0 to 3 cases | | 3 to 6 cases | | 6 to 10 cases | | Over 10 cases | |
|---|---|---|---|---|---|---|---|---|
| | No. | % | No. | % | No. | % | No. | % |
| Boy (0-18 yrs.) | 191 | 40.7 | 36 | 7.7 | 8 | 1.7 | 18 | 3.8 |
| Girl (0-18 yrs.) | 193 | 41.0 | 38 | 8.1 | 23 | 4.9 | 15 | 3.2 |
| Woman (18-64 yrs.) | 164 | 34.7 | 55 | 11.2 | 28 | 5.9 | 32 | 6.8 |
| Man (18-64 yrs.) | 142 | 30.4 | 12 | 2.6 | 13 | 2.8 | 16 | 3.4 |
| Elderly Man (over 64) | 160 | 34.3 | 18 | 3.9 | 3 | 0.6 | 10 | 2.1 |
| Elderly Woman (over 64) | 173 | 37.0 | 24 | 5.1 | 5 | 1.1 | 9 | 1.9 |

## TABLE 21

## NUMBER OF CASES OF VICTIMS ENCOUNTERED DURING THE LAST YEAR BY REGION

| Cases | | Region | | | | | | Total |
|---|---|---|---|---|---|---|---|---|
| | | 1 | 2 | 3 | 4 | 5 | 6 | |
| 0-3 cases | # | 26 | 25 | 31 | 27 | 27 | 23 | 159 |
| | % | 8.9 | 8.6 | 10.6 | 9.2 | 9.2 | 7.9 | 54.5 |
| 3-6 cases | # | 8 | 10 | 15 | 14 | 10 | 9 | 66 |
| | % | 2.7 | 3.4 | 5.1 | 4.8 | 3.4 | 3.1 | 22.6 |
| 6-10 cases | # | 6 | 5 | 11 | 8 | 0 | 3 | 33 |
| | % | 2.1 | 1.7 | 3.8 | 2.7 | 0.0 | 1.0 | 11.3 |
| Over 10 cases | # | 6 | 5 | 8 | 2 | 11 | 2 | 34 |
| | % | 2.1 | 1.7 | 2.7 | 0.7 | 3.8 | 0.7 | 11.6 |
| COLUMN TOTAL | # | 46 | 45 | 65 | 51 | 48 | 37 | 292 |
| | % | 15.8 | 15.4 | 22.3 | 17.5 | 16.4 | 12.7 | 100.0 |

## TABLE 22

## TYPE OF VICTIMS ENCOUNTERED BY SURVEY RESPONDENTS DURING THE LAST YEAR BY REGION

| Victim | | Region | | | | | | Total |
|---|---|---|---|---|---|---|---|---|
| | | W.Tx. | NW Tx. | S.Tx. | Ce.Tx. | E.Tx. | NE Tx. | |
| Boy (0-18 yrs.) | # | 0 | 1 | 1 | 2 | 0 | 3 | 7 |
| | % | 0.0 | 0.3 | 0.3 | 0.7 | 0.0 | 1.0 | 2.4 |
| Girl (0-18 yrs.) | # | 3 | 3 | 10 | 2 | 2 | 2 | 22 |
| | % | 1.0 | 1.0 | 3.4 | 0.7 | 0.7 | 0.7 | 7.5 |
| Woman (18-64 yrs.) | # | 10 | 11 | 12 | 6 | 12 | 11 | 62 |
| | % | 3.4 | 3.8 | 4.1 | 2.1 | 4.1 | 3.8 | 21.2 |
| Man (18-64 yrs.) | # | 5 | 2 | 4 | 3 | 3 | 2 | 19 |
| | % | 1.7 | 0.7 | 1.4 | 1.0 | 1.0 | 0.7 | 6.5 |
| Elderly man (over 64) | # | 3 | 0 | 1 | 1 | 3 | 2 | 10 |
| | % | 1.0 | 0.0 | 0.3 | 0.3 | 1.0 | 0.7 | 3.4 |
| Elderly woman (over 64) | # | 25 | 28 | 37 | 37 | 28 | 17 | 172 |
| | % | 8.6 | 9.6 | 12.7 | 12.7 | 9.6 | 5.8 | 58.9 |
| COLUMN TOTAL | # | 46 | 45 | 65 | 51 | 48 | 37 | 292 |
| | % | 15.8 | 15.4 | 22.3 | 17.5 | 16.4 | 12.7 | 100.0 |

### Quality of Support from Referral Services

The respondents were asked to rate the quality of support received from referral services utilized. The results are shown in Table 23. Analysis of the data shows that all referral services listed were rated as providing "good support" by a minimum of 15.2 percent and a maximum of 88.8 percent. More respondents rated a service as "good support" than rated a service as "poor support." (The category "other" was not included because it may contain more than one referral service and is non-descriptive.) Referral services rated by respondents as providing "good support" are ranked in Table 24.

When each service was examined on a regional basis for quality of support significant differences between regions were found only for the category "Court support." The report of poor quality support from the courts in region 1 was significantly greater than expected and the report of good court support was less than expected. This may be due to the lack of court systems in the region 1, or west Texas, area.

TABLE 23

QUALITY OF SUPPORT RECEIVED FROM REFERRAL SERVICES UTILIZED BY RESPONDENTS

| Referral Service | Good Support |  | Poor Support |  |
|---|---|---|---|---|
|  | Number | Percentage | Number | Percentage |
| Police | 186 | 89.0 | 23 | 11.0 |
| Churches | 140 | 91.5 | 13 | 8.5 |
| Battered women's shelters | 34 | 57.6 | 25 | 42.4 |
| Child welfare | 128 | 79.0 | 34 | 21.0 |
| Social service agencies | 99 | 80.5 | 24 | 19.5 |
| Hospital | 126 | 92.6 | 10 | 7.4 |
| Physician | 134 | 94.4 | 8 | 5.6 |
| Legal aid | 46 | 66.7 | 23 | 33.3 |
| Emergency room | 114 | 87.7 | 16 | 12.3 |
| Court | 64 | 77.1 | 19 | 22.9 |
| Lawyer | 58 | 73.4 | 21 | 26.6 |
| Nurses | 89 | 93.7 | 6 | 6.3 |
| Emergency medical services | 81 | 91.0 | 8 | 9.0 |
| Department of Human Resources | 129 | 88.4 | 17 | 11.6 |
| Counselors | 64 | 77.1 | 19 | 22.9 |
| Other | 6 | 54.5 | 5 | 45.5 |

TABLE 24

QUALITY OF SUPPORT RECEIVED FROM REFERRAL SERVICES
UTILIZED BY RESPONDENTS IN RANK ORDER FOR
"GOOD SUPPORT"

| Referral Service | "Good Support" Percentage |
|---|---|
| Physician | 94.4 |
| Nurses | 93.7 |
| Hospital | 92.6 |
| Churches | 91.5 |
| Emergency medical services | 91.0 |
| Police | 89.0 |
| Department of Human Resources | 88.4 |
| Emergency room | 87.7 |
| Social service agency | 80.5 |
| Child welfare | 79.0 |
| Counselors | 77.1 |
| Court | 77.1 |
| Lawyer | 73.4 |
| Legal aid | 66.7 |
| Battered women's shelter | 57.6 |

## Priorities of Service Needs

Priorities of service needs for domestic violence victims are presented in Table 25. The large number of missing cases (N=333 to N=464) makes interpretation tenuous. However, the responses indicate that police (N=96), child welfare (N=96), Department of Human Resources (N=83), and physician services (N=82) were the top four priorities perceived as "greatly needed." The four most frequently selected services perceived as "not needed" were emergency medical services (N=15), battered women's shelters (N=15), court services

(N=15) and lawyers (N=14). When this data was evaluated on a regional basis the only significant differences in priorities for needed services were found in the legal aid category. Regions 4 and 5 felt that legal aid was more greatly needed than did regions 3 and 6.

TABLE 25

PRIORITIES OF SERVICE NEEDS FOR DOMESTIC VIOLENCE VICTIMS

| Services | Greatly Needed |  | Somewhat Needed |  | Not Needed |  |
|---|---|---|---|---|---|---|
|  | No. | % | No. | % | No. | % |
| Police | 96 | 65.8 | 40 | 27.4 | 10 | 6.8 |
| Churches | 66 | 57.9 | 35 | 30.7 | 13 | 11.4 |
| Battered women's shelters | 67 | 65.7 | 20 | 19.6 | 15 | 14.7 |
| Child welfare | 96 | 71.6 | 29 | 21.6 | 9 | 6.7 |
| Social service agencies | 79 | 65.3 | 32 | 26.4 | 10 | 8.3 |
| Hospital | 73 | 68.2 | 22 | 20.6 | 12 | 11.2 |
| Physician | 82 | 68.9 | 27 | 22.7 | 10 | 8.4 |
| Legal aid | 54 | 55.1 | 32 | 32.7 | 12 | 12.2 |
| Emergency room | 70 | 65.4 | 24 | 22.4 | 13 | 12.1 |
| Court | 41 | 44.6 | 36 | 39.1 | 15 | 16.3 |
| Lawyer | 42 | 45.2 | 37 | 39.8 | 14 | 15.1 |
| Nurse | 55 | 61.8 | 21 | 23.6 | 13 | 14.6 |
| Emergency medical services | 55 | 59.8 | 21 | 22.8 | 16 | 17.4 |
| Department of Human Resources | 83 | 70.3 | 24 | 20.3 | 11 | 9.3 |
| Counselors | 72 | 72.0 | 18 | 18.0 | 10 | 10.0 |
| Other (specify) | 10 | 66.7 | 3 | 20.0 | 2 | 13.3 |

## Survey Comments Analysis

One hundred and sixty health/human service professionals (35% of those answering the questionnaire) responded to questions 13 and 14. Question 13 asked "Are there any other factors which you feel interfere with your ability to serve domestic violence victims?" Question 14 asked for "any comments you have about the questionnaire, your concerns about domestic violence in rural areas or your educational needs."

One hundred and eighty-two comments were made in response to Question 13 (Table 26). Lack of awareness/support from the community was the factor most frequently cited as interfering with the health/human service professionals' ability to serve domestic violence victims, followed by the factors of politics/court system/law enforcement, unwilling/uncooperative victim/denial by victim/abuser, and lack or inadequacy of specific resource/facility.

## TABLE 26

## RESULTS OF CONTENT ANALYSIS OF COMMENTS ON SURVEY QUESTION 13

**Are there any other factors which you feel interfere with your ability to serve domestic violence victims?**

| Answer Category | Number | Percent |
|---|---|---|
| 1. Type of facility/agency/does not provide services | 15 | 8.2 |
| 2. Size of community/lack of anonymity | 3 | 1.7 |
| 3. Age/time/physical limitations of individual | 11 | 6.0 |
| 4. Lack of awareness/support from community | 23 | 12.6 |
| 5. Lack of awareness/support from professionals/ public officials | 6 | 3.3 |
| 6. Lack or inadequacy of specific resource/ facility | 18 | 9.9 |
| 7. Politics/court system/law enforcement | 21 | 11.5 |
| 8. Lack of funds/poverty/economic difficulty | 6 | 3.3 |
| 9. Lack of information/training | 12 | 6.6 |
| 10. Unwilling/uncooperative victim/denial by victim/abuser | 21 | 11.5 |
| 11. Victims return to same environment/ economic dependence | 4 | 2.2 |
| 12. Resistance to outside interference | 2 | 1.1 |
| 13. Lack of coordination/communication between agencies | 2 | 1.1 |
| 14. Cultural/language barriers | 3 | 1.7 |
| 15. Failure to report/identify domestic violence | 15 | 8.3 |
| 16. Little or no violence in community/do not see cases | 10 | 5.5 |
| 17. Other | 10 | 5.5 |
| TOTAL | 182 | 100.0 |

There were 270 comments made to Question 14 and these covered a broad range of concerns (Table 27). Over 16% of the comments were in the category of domestic violence was not a problem or that the respondent had no or few calls, followed by 12.2% in the category need training/education/information.

TABLE 27

RESULTS OF CONTENT ANALYSIS OF COMMENTS ON SURVEY QUESTION 14

**Please add any comments you have about the questionnaire, your concerns about domestic violence in rural areas or your educational needs.**

| Answer Category | Number | Percent |
|---|---|---|
| 1. Not a problem/no or few calls | 44 | 16.3 |
| 2. Case histories/specific descriptions of cases | 4 | 1.5 |
| 3. Interested in program/results/offer assistance | 12 | 4.4 |
| 4. Cultural/stereotypical views of victim/abuser | 11 | 4.1 |
| 5. Existing resources are adequate | 14 | 5.2 |
| 6. Poor case reporting/recognition | 16 | 5.9 |
| 7. Individual/agency referral procedures | 5 | 1.9 |
| 8. Statistics not available/too hard to get | 5 | 1.9 |
| 9. Questionnaire not applicable to individual/agency/community | 26 | 9.6 |
| 10. Need training/education/information | 33 | 12.2 |
| 11. Lack specific resources/inadequate resources | 16 | 5.9 |
| 12. Lack funds | 2 | 0.7 |
| 13. Politics/court system/law enforcement | 8 | 2.9 |
| 14. Questionnaire mailing procedure | 4 | 1.5 |
| 15. Unwilling/uncooperative victim/denial by victim/abuser | 6 | 2.2 |
| 16. Economic dependence of victim/no place to go | 3 | 1.1 |
| 17. Religious/moral/philosophical | 4 | 1.5 |
| 18. Lack of awareness or denial of problem by community | 14 | 5.2 |
| 19. Questionnaire too detailed/took too long/confusing | 5 | 1.9 |
| 20. Alcohol/drug abuse and domestic violence | 6 | 2.2 |
| 21. Good questionnaire/program/important issue | 9 | 3.3 |
| 22. Increasing domestic violence | 5 | 1.9 |
| 23. Travel distance/transportation | 4 | 1.5 |
| 24. Other | 14 | 5.2 |
| TOTAL | 270 | 100.0 |

## Interview Data

### Interview Procedures

Five health/human service professionals were randomly interviewed at each of the five conferences. A structured interview format was utilized (Appendix D). Interviews varied in length from 5-20 minutes. Interview questions were formulated based on the response to the survey questionnaire.

### Interview Data Analysis

Over 20% of the interviewees' responses identified the lack of resources or few and/or inadequate resources as the unique problem in the delivery of services to domestic violence victims in rural Texas, with lack of awareness/lack of support from the community being the category of next highest response rate (Table 28).

## TABLE 28

## RESULTS OF CONTENT ANALYSIS OF INTERVIEW QUESTION 1

**As a rural provider, what do you feel are the unique problems and needs related to the delivery of services to domestic violence victims in rural Texas?**

| Answer Category | Number | Percent |
|---|---|---|
| Lack of resources/few and/or inadequate resources | 9 | 20.4 |
| Travel distance/transportation | 4 | 9.1 |
| Lack of cooperation/resistance to outside help | 4 | 9.1 |
| Political/legal/court system/police | 1 | 2.3 |
| Stereotypical or negative community attitudes | 1 | 2.3 |
| Lack of support from professionals/public officials | 4 | 9.1 |
| Lack of funds | 7 | 15.9 |
| Cultural/language barriers | 2 | 4.5 |
| Lack of awareness/support from community | 7 | 15.9 |
| Other | 5 | 11.4 |
| TOTAL | 44 | 100.0 |

Almost twice as many interviewees (yes N=16, no N=9, Table 29) felt that their communities dealt differently with domestic violence, depending on the victim. More respondents to the interviews in Alpine (west Texas) and Victoria (south Texas) felt that their communities handled the victims of abuse differently than the respondents from Gainesville, Lubbock and Nacogdoches.

### TABLE 29

### PERCEPTION OF DIFFERENCE IN COMMUNITY'S ATTITUDE TOWARD DEALING WITH CHILD ABUSE, SPOUSE ABUSE, AND ELDERLY ABUSE

**Is there a difference in your community's attitude toward dealing with child abuse, spouse abuse, and elderly abuse?**

| Responses by Conference | | Answer | |
|---|---|---|---|
| | | Yes | No |
| Alpine | # | 4 | 1 |
| | % | 25.0 | 11.1 |
| Gainesville | # | 2 | 3 |
| | % | 12.5 | 33.3 |
| Victoria | # | 4 | 1 |
| | % | 25.0 | 11.1 |
| Lubbock | # | 3 | 2 |
| | % | 18.8 | 22.2 |
| Nacogdoches | # | 3 | 2 |
| | % | 18.8 | 22.2 |
| TOTAL | # | 16 | 9 |
| | % | 100.1%* | 99.9%* |

*Does not equal 100% due to rounding. All percents are column percents.

Respondents who felt that there were differences in their community's attitude toward dealing with the different victims of domestic violence tended to see child abuse as more serious than other forms of abuse because children were helpless or innocent victims. They felt their communities perceived spouses and the elderly as adults with options, or they felt violence among adult family members was a family matter and tended to deny or ignore the problem. Some respondents concluded that their community's lack of awareness and understanding of elderly abuse led to differences in dealing with elderly victims (Table 30).

TABLE 30

RESULTS OF CONTENT ANALYSIS OF INTERVIEW QUESTION 3

**How does your community's attitude differ toward each: child abuse, spouse abuse, elderly abuse?**

| Answer Category | Number | Percent |
|---|---|---|
| **Spouse Abuse** | | |
| Ignore/deny problem | 1 | 6.3 |
| Stereotypical/negative attitudes | 5 | 31.3 |
| Victims are adults with options | 7 | 43.7 |
| Other | 3 | 18.7 |
| TOTAL | 16 | 100.0 |
| **Child Abuse** | | |
| Children are helpless/innocent victims | 8 | 66.7 |
| Child abuse more serious than other abuse | 3 | 25.0 |
| Other | 1 | 8.3 |
| TOTAL | 12 | 100.0 |
| **Elderly Abuse** | | |
| Victims are adults with options | 2 | 25.0 |
| Lack of awareness | 3 | 37.5 |
| Ignore/deny problem | 1 | 12.5 |
| Other | 2 | 25.0 |
| TOTAL | 8 | 100.0 |

During each interview the respondent was asked to indicate how many cases of each type of abuse she/he encountered during the last year (Table 31). All those interviewed had seen at least one case of abuse during the previous year. The victims most frequently seen were women and children. The highest overall number of responses were in the 0 case and 1-2 cases categories. In the 0 case category the largest number of responses occurred for men (18-64 or over) and the smallest number for women (18-64). The largest percentage of cases in the 1-2 case category were girls (0-18 years) and elderly women (over 64). In the 3-5 case category women victims (18-64 years) were seen most frequently, and elderly men and girls least frequently. Forty-three percent of the responses in the 6-10 case category were reported for boys (0-18 years). No responses were reported in the 6-10 case category for men or elderly women. Sixty percent of the responses for the over 10 case category were for women victims; the next largest number of responses were for girls (0-18 years). None of the respondents reported seeing 10 or more cases of abuse against men (18-64 years) or the elderly (women and men over 64).

70

## TABLE 31

## NUMBERS AND TYPES OF VICTIMS SEEN BY RESPONDENTS TO ALL INTERVIEWS

| Victim | | Cases | | | | | |
|---|---|---|---|---|---|---|---|
| | | 0 cases | 1-2 cases | 3-5 cases | 6-10 cases | Over 10 cases | TOTAL |
| Boy (0-18 yrs.) | # | 12 | 5 | 3 | 3 | 1 | 24 |
| | % | 17.9 | 10.6 | 23.1 | 42.9 | 10.0 | 16.7 |
| Girl (0-18 yrs.) | # | 7 | 11 | 1 | 2 | 3 | 24 |
| | % | 10.4 | 23.4 | 7.7 | 28.6 | 30.0 | 16.7 |
| Woman (18-64 yrs.) | # | 3 | 8 | 5 | 2 | 6 | 24 |
| | % | 4.5 | 17.0 | 38.5 | 28.6 | 60.0 | 16.7 |
| Man (18-64 yrs.) | # | 15 | 8 | 1 | 0 | 0 | 24 |
| | % | 22.4 | 17.0 | 7.7 | 0.0 | 0.0 | 16.7 |
| Elderly man (over 64) | # | 19 | 4 | 1 | 0 | 0 | 24 |
| | % | 28.4 | 8.5 | 7.7 | 0.0 | 0.0 | 16.7 |
| Elderly woman (over 64) | # | 11 | 11 | 2 | 0 | 0 | 24 |
| | % | 16.4 | 23.4 | 15.4 | 0.0 | 0.0 | 16.7 |
| COLUMN TOTAL | # | 67 | 47 | 13 | 7 | 10 | 144 |
| | % | 100.0 | 99.9 | 100.1 | 100.1 | 100.0 | 100.2 |
| ROW PERCENT | | 46.5 | 32.6 | 9.0 | 4.9 | 6.9 | |

*Does not equal 100% due to rounding. All percents are column percents except where noted.

Twenty-one percent of all the responses fell into the 3 or over case categories. The 1-2 case category contained 33% of all the responses and 47% of the responses fell into the 0 case category.

The fewest number of cases of abuse were seen by the respondents from the Alpine conference (Appendix G, Table 50). Alpine respondents also reported the largest number of responses in the 0 case category.

In Lubbock the largest number of responses fell in the 1-2 case category (Appendix G, Table 51) and the fewest in the 3-5 case category.

The largest number of responses for cases of victims seen by those interviewed during the Victoria conference fell into the 1-2 case category and the fewest responses occurred in the 6-10 case category (Appendix G, Table 52).

No responses in the 6-10 case or the over 10 case categories were reported by anyone at the Gainesville conference and the largest number of responses fell into the 0 case category (Appendix G, Table 53).

Results from interviews done during the Nacogdoches conference indicate that no respondents saw 6-10 cases of any type of abuse and only one person saw more than 10 cases of abuse. The victims encountered by the person seeing greater than 10 cases were women (18-64 years). Most of the responses were reported in the 0 case category (Appendix G, Table 54).

When asked which group of domestic violence victims the conference participants knew the least about, 16 of the 24 people interviewed reported that they had the least knowledge of elderly abuse. Only two respondents felt they knew less about child abuse than another victim group (Table 32). These findings corroborate the general lack of information and understanding of elderly abuse. They also point out that when a problem such as child abuse is well researched and publicized, the general knowledge level increases.

## TABLE 32

## GROUP OF DOMESTIC VIOLENCE VICTIMS THE RESPONDENTS KNEW THE LEAST ABOUT

| Conference | | Victim Group | | |
|---|---|---|---|---|
| | | Child | Spouse | Elderly |
| Alpine | # | 0 | 2 | 3 |
| | % | 0.0 | 50.0 | 18.8 |
| Gainesville | # | 0 | 1* | 3 |
| | % | 0.0 | 25.0 | 18.8 |
| Victoria | # | 0 | 0 | 5 |
| | % | 0.0 | 0.0 | 31.3 |
| Lubbock** | # | 1 | 0 | 3 |
| | % | 50.0 | 0.0 | 18.8 |
| Nacogdoches | # | 1 | 1* | 2 |
| | % | 50.0 | 25.0 | 12.5 |
| COLUMN TOTAL | # | 2 | 4 | 16 |
| | % | 100.0 | 100.0 | 99.9 |

* Omitted by 1 person

** Double response by one person (child and elderly), therefore omitted.

Each respondent was asked to specify what specific needs for education and training would help them to better serve the needs of the group of victims they knew least about. Intervention techniques and all types of information on domestic violence were the specific training and information needs mentioned most frequently by interviewees. The need to increase awareness of the problem was the next most frequent response (Table 33).

TABLE 33

RESULTS OF CONTENT ANALYSIS OF INTERVIEW QUESTION 6

**To best serve the group identified in question 5, what are your specific needs for information and training?**

| Answer Category | Number | Percent |
|---|---|---|
| All types of information | 6 | 17.7 |
| Counseling techniques | 3 | 8.8 |
| Referral resources | 2 | 5.9 |
| Victim identification | 3 | 8.8 |
| Intervention techniques | 6 | 17.7 |
| Types of abuse and incidence | 2 | 5.9 |
| Increased awareness | 5 | 14.7 |
| More conferences | 2 | 5.9 |
| Other | 5 | 14.7 |
| TOTAL | 34 | 100.1* |

*Does not equal 100.0% due to rounding.

# PROGRAM EVALUATION

## Evaluation Approach

A process and outcome approach was used to evaluate the Rural Texas Domestic Violence Health Professionals Education Program. Based on the RTDVHPEP purpose and goals, objectives for each phase of the program were established, a work plan was developed, and an indicator of objective achievement was specified.

Methods for objective achievement were enumerated. Input on concept and process from (1) professionals with expertise in delivery of services to victims of domestic violence, rural health care delivery, research, conference and evaluation design and development of networks, (2) conference participants, and (3) the Texas Council on Family Violence were specified in the methodology.

After Phase II, Design Conference, an evaluation of program progress was completed. Based on this evaluation, modifications were made in the original work plan These modifications included increasing time for technical assistance to communities and health/human service providers, additional data collection and analysis, completing a resource list instead of a directory, and decreasing the actual project time period by two months.

## Conference Evaluation Approach

At the conclusion of each of the five conferences the participants were asked to evaluate the conference. Suggestions for conferences changes were solicited. The evaluations of preceding conferences were utilized in the planning and conduction of all the conferences except the first at Alpine.

A month after each conference a random sample of conference participants were sent an evaluation questionnaire. The evaluation form was structured to determine if the outcomes expected by the conference planners had occurred.

## Conference Evaluations

An evaluation form was provided to each conference participant in their packet of conference materials. The participants were asked to fill the evaluation out at the end of the conference or prior to their leaving. Table 34 indicates that 35-55% of the conference participants returned the evaluation form.

TABLE 34

NUMBER AND PERCENT OF CONFERENCE EVALUATIONS COMPLETED

| Conference Location | Number Registered Conference Participants | Number Conference Evaluations Completed | Percent of Evaluation Forms Completed by Registered Conference Participants |
|---|---|---|---|
| Alpine | 72 | 34 | 47% |
| Gainesville | 136 | 60 | 44% |
| Victoria | 188 | 67 | 36% |
| Lubbock | 64 | 35 | 55% |
| Nacogdoches | 158 | 66 | 42% |

The evaluation form (Appendix C) contained several questions asking for a rating of from 1-5 and several open ended questions. The overall rating for all of the conferences was 4.09. Table 35 contains the mean ratings by conference, by question and overall.

TABLE 35

CONFERENCE EVALUATIONS: INDIVIDUAL AND OVERALL MEAN SCORES

| Evaluation Question | Conference Location | | | | | Total Mean |
|---|---|---|---|---|---|---|
| | Alpine | Gainesville | Victoria | Lubbock | Nacogdoches | |
| | Mean | Mean | Mean | Mean | Mean | |
| 1. In general, how would you rate this conference? | 4.08 | 4.13 | 3.89 | 4.40 | 3.96 | 4.09 |
| 2. How well do you feel that this conference prepared you to: | | | | | | |
| a. Assess and intervene with victims | 3.80 | 3.85 | 3.49 | 3.97 | 3.60 | 3.74 |
| b. Identify statewide resources and referral agencies | 3.90 | 4.15 | 4.14 | 4.10 | 3.74 | 4.01 |
| c. Assess community resources | 3.78 | 3.72 | 3.77 | 4.03 | 3.76 | 3.81 |
| d. Identify the role of law enforcement | 3.30 | 3.66 | 3.79 | 4.30 | 3.80 | 3.77 |

The responses to the open ended questions were content analyzed. There were 325 comments made in response to the question "What did you like best about the conference?" The majority (51.7%) of the comments (Table 36) were in the categories of "general speakers," "particular speaker", "particular workshop," and "everything."

On the question "What did you like least about the conference?" the largest group of comments (14%) were in the category "particular speaker" (Table 37). The next most frequent comments were in the category of "facilities," followed by the categories "nothing" and "the conference or individual presentation was too short."

Two hundred and twenty six comments were made in response to the question "What changes could be made to improve this conference?" The category of most frequent comment was "suggested topic" (12.8%) followed by the categories "make the conference 2 days/longer" (12%), "rearrange speakers, workshops and breaks" (11.1%) and "nothing" (10.2%). Table 38 gives the number of comments by category.

TABLE 36

RESULTS OF CONTENT ANALYSIS OF COMMENTS ON EVALUATION FORM QUESTION 3

**What did you like best about the conference?**

| **Answer** Categories | Number of Comments | **Percent** |
|---|---|---|
| 1. General speakers | 50 | 15.4 |
| 2. Particular speaker | 45 | 13.8 |
| 3. General workshop(s) | 12 | 3.7 |
| 4. Particular workshop | 49 | 15.1 |
| 5. General films | 20 | 6.2 |
| 6. Particular film | 11 | 3.4 |
| 7. Conference atmosphere/focus | 12 | 3.7 |
| 8. Conference organization | 18 | 5.5 |
| 9. Facilities | 4 | 1.2 |
| 10. Handouts/packets | 4 | 1.2 |
| 11. Adequacy of information presented | 17 | 5.2 |
| 12. Breadth of information presented | 15 | 4.6 |
| 13. Date/day of conference/place | 4 | 1.2 |
| 14. Information gained | 7 | 2.2 |
| 15. Increased awareness | 10 | 3.1 |
| 16. Religious/moral/philosophical | 5 | 1.5 |
| 17. Everything | 24 | 7.4 |
| 18. Other | 7 | 2.2 |
| 19. More time/conferences/information | 2 | 0.6 |
| 20. Fact held/bringing people together | 9 | 2.8 |
| TOTAL | 325 | 100.0% |

## TABLE 37

## RESULTS OF CONTENT ANALYSIS OF COMMENTS ON EVALUATION FORM QUESTION 4

**What did you like least about the conference?**

| Answer Categories | Number of Comments | Percent |
|---|---|---|
| 1. Speakers in general | 14 | 6.3 |
| 2. Particular speaker | 31 | 14.0 |
| 3. Particular workshop | 9 | 4.1 |
| 4. Poor organization | 4 | 1.8 |
| 5. Lack of specifics/general information | 12 | 5.4 |
| 6. Too much going on at same time | 14 | 6.3 |
| 7. Weather | 6 | 2.7 |
| 8. Faulty equipment/operators/no sound system | 15 | 6.8 |
| 9. Facilities--size, temperature, parking, etc. | 20 | 9.1 |
| 10. Redundant information | 8 | 3.6 |
| 11. Missing information | 14 | 6.3 |
| 12. Location/date | 2 | 1.0 |
| 13. Too long/part or all of program | 9 | 4.1 |
| 14. Too short/longer conference or individual presentation | 19 | 8.6 |
| 15. Nothing | 19 | 8.6 |
| 16. Poor scheduling/speaker too long, etc. | 5 | 2.3 |
| 17. Other | 14 | 6.3 |
| 18. Too many statistics | 6 | 2.7 |
| TOTAL | 221 | 100.0% |

TABLE 38

RESULTS OF CONTENT ANALYSIS OF COMMENTS ON EVALUATION FORM QUESTION 5

**What changes could be made improve this conference?**

| Answer Categories | Number of Comments | Percent |
|---|---|---|
| 1. Nothing | 23 | 10.2 |
| 2. Make conference 2 days/longer/future events/more time | 27 | 12.0 |
| 3. Rearrange speakers, workshops and/or breaks | 25 | 11.1 |
| 4. More visual aids | 2 | 0.8 |
| 5. More group discussion/participation | 18 | 8.0 |
| 6. Improve registration | 3 | 1.3 |
| 7. Weather | 3 | 1.3 |
| 8. Change/improve information quality/content | 8 | 3.5 |
| 9. Different day | 2 | 0.8 |
| 10. Suggested topics | 29 | 12.8 |
| 11. Suggested speakers | 14 | 6.2 |
| 12. Speaker changes/suggestions, criticisms | 12 | 5.3 |
| 13. Workshop changes | 6 | 2.6 |
| 14. Better organization | 4 | 1.8 |
| 15. Other | 17 | 7.5 |
| 16. Packet additions/handouts | 7 | 3.1 |
| 17. On schedule | 4 | 1.8 |
| 18. Fix so everyone could do everything | 8 | 3.5 |
| 19. Different facilities/hold everything in same building/equipment | 14 | 6.2 |
| TOTAL | 226 | 100.0% |

Overall the comments were positive:

> Perhaps the very best aspect was the issue of presenting much needed information with some awareness that the issues in a rural area are different than the issues in an urban area.[7]

> Everything was exceptionally well done and I feel I have learned something. Thank you.[7]

> People attended from the rural communities and Lubbock, which helped us meet each other and network for future teamwork. The excitement of working together as a group helped break the social isolation we often feel working in this area.[8]

and the need for more conferences was expressed:

> It would help to have this kind of conference more often.[9]

> A good beginning--maybe an in-depth followup in specific areas.[9]

> I hope that more conferences of this nature are planned for the future.[9]

> I had a great learning experience which I didn't realize could have taken place at a conference. Will attend again.[10]

## Follow-Up Conference Evaluations

Follow-up evaluation forms (Appendix E) were sent to every third registered conference participant. The participants were asked to fill out the evaluation form and mail it back. Table 39 indicates that 20% to 47% of the participants surveyed returned their evaluations, with an overall average of 32%.

### TABLE 39
### NUMBER AND PERCENT OF CONFERENCE EVALUATIONS COMPLETED

| Conference Location | Number of Registered Conference Participants Surveyed | Number of Follow-up Evaluations Completed | Percent of Evaluation Forms Completed |
|---|---|---|---|
| Alpine | 24 | 7 | 29% |
| Gainesville | 45 | 15 | 33% |
| Victoria | 62 | 13 | 20% |
| Lubbock | 21 | 10 | 47% |
| Nacogdoches | 52 | 21 | 40% |
| TOTALS | 204 | 66 | 32% |

Responses were received from six professional groups (Table 40). Social workers represented the largest professional category with 23 respondents. The categories "clergy" and "justice of the peace" represented the smallest, with one respondent each. No responses were received from physicians or hospital administrators. There are two possible explanations for this. First, the follow-up evaluations were mailed to a random selection of conference participants and therefore no attempt was made to insure a representative sample by profession. Second, the conferences were not widely attended by these provider groups. Thirty percent of the responses were from the professional category "other," which consisted mainly of students, shelter volunteers, and law enforcement officers.

## TABLE 40
## RESPONDENTS TO FOLLOW-UP EVALUATION BY PROFESSION

| Profession | Number of respondents | Percent of Total |
|---|---|---|
| Physician | 0 | 0 |
| Nurse, nurse practitioner, physician assistant | 14 | 21.2 |
| EMT, paramedic, ECA | 7 | 10.6 |
| Social worker, psychologist, mental health worker, counselor | 23 | 34.8 |
| Hospital administrator | 0 | 0 |
| Clinic administrator, community center administrator, child care facility administrator | 0 | 0 |
| Clergy | 1 | 1.5 |
| Justice of the Peace | 1 | 1.5 |
| Other | 20 | 30.3 |
| TOTALS | 66 | 100.0 |

Conference participants were asked to evaluate topic areas of the conferences, indicating whether the conference provided or did not provide information needed to improve their ability to serve victims of domestic violence. The greatest number (59) of respondents (Table 41) felt that general information was both needed and provided. Eleven respondents felt that information on fundraising was provided but not needed, and 20 respondents felt that information on fundraising was needed but not provided. A possible explanation for this discrepancy is the fact that not all conferences contained workshops on funding. In addition, the workshops that were offered on fundraising were poorly attended. In general, all respondents felt that the conferences provided them with the information they needed on domestic violence.

## TABLE 41
## RESPONDENTS' PERCEPTION OF WHETHER NEEDED INFORMATION WAS PROVIDED OR NOT PROVIDED AT THE CONFERENCE

| Type of information | Provided needed information | | Provided information not needed | | Information needed but not provided | |
|---|---|---|---|---|---|---|
| | No. | %* | No. | %* | No. | %* |
| General information | 59 | 92% | 2 | 3% | 3 | 5% |
| Diagnosis and intervention with victims | 45 | 79% | 3 | 5% | 9 | 16% |
| Counseling techniques | 35 | 63% | 5 | 9% | 16 | 29% |
| Building community support | 39 | 70% | 4 | 7% | 13 | 23% |
| Statewide and regional resources | 51 | 86% | 2 | 3% | 6 | 10% |
| Legal and law enforcement issues | 53 | 87% | 4 | 7% | 4 | 7% |
| Fundraising | 23 | 41% | 11 | 20% | 22 | 39% |
| Community health assessment | 35 | 64% | 7 | 13% | 13 | 24% |

*Percentages were rounded to nearest whole number.

When the types of information were ranked on a profession by profession basis nurses, social workers and the professional category "other" all felt that general information was most needed and was provided. Across all professions general information, legal and law enforcement issues, and information on statewide and regional resources were perceived as provided and most needed. The types of information which were provided but perceived as least needed were counseling and fundraising (Table 42).

Respondents were asked to look back on individuals they had provided services to in the past to decide if some of them were abuse victims which they did not identify as such at the time. Twenty-seven, or 42.9% (Table 43),

## TABLE 42
## RANK OF RESPONDENTS' PERCEPTION OF WHETHER NEEDED INFORMATION WAS PROVIDED OR NOT PROVIDED AT THE CONFERENCE BY PROFESSION

| | Profession | | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | Nurse, nurse practitioner, physician's assistant | | | EMT, paramedic, ECA | | | Social worker, psychologist, mental health worker, counselor | | | Clergy | | | Justice of the Peace | | | Other | | | Total Number | $M_G$ | Rank* Overall |
| Type of information | Rank* | No. | Mean | Rank* | No. | Mean | Rank* | No. | Mean | Rank* | No. | Mean | Rank* | No. | Mean | Rank* | No. | Mean | | | |
| General information | 1.0 | 14 | 1.0 | 3.5 | 7 | 1.43 | 1.0 | 23 | 1.13 | 2.0 | 1 | 1.00 | 2.5 | 1 | 1.00 | 1.0 | 18 | 1.11 | 64 | 1.13 | 1 |
| Diagnosis and intervention with victims | 4.0 | 13 | 1.23 | 1.0 | 6 | 1.00 | 4.0 | 20 | 1.40 | 6.5 | 1 | 3.00 | 7.0 | 1 | 3.00 | 5.0 | 16 | 1.38 | 52 | 1.37 | 4 |
| Counseling techniques | 6.0 | 13 | 1.38 | 7.0 | 6 | 1.83 | 5.0 | 20 | 1.55 | 6.5 | 1 | 3.00 | 7.0 | 1 | 3.00 | 7.0 | 15 | 1.80 | 56 | 1.66 | 7 |
| Building community support | 8.0 | 12 | 1.67 | 2.0 | 6 | 1.33 | 7.0 | 20 | 1.75 | 2.0 | 1 | 1.00 | 2.5 | 1 | 1.00 | 4.0 | 16 | 1.31 | 56 | 1.54 | 5 |
| Statewide resources | 3.0 | 13 | 1.15 | 5.5 | 7 | 1.57 | 3.0 | 21 | 1.24 | 2.0 | 1 | 1.00 | 5.0 | 1 | 2.00 | 2.5 | 16 | 1.13 | 59 | 1.24 | 3 |
| Legal and law enforcement issues | 2.0 | 14 | 1.07 | 5.5 | 7 | 1.57 | 2.0 | 22 | 1.14 | 6.5 | 1 | 3.00 | 2.5 | 1 | 1.00 | 2.5 | 16 | 1.13 | 61 | 1.20 | 2 |
| Fundraising | 7.0 | 12 | 1.58 | 8.0 | 6 | 2.00 | 8.0 | 2[illegible] | 2.15 | 4.0 | 1 | 2.00 | 7.0 | 1 | 3.00 | 8.0 | 16 | 2.00 | 56 | 1.98 | 8 |
| Health assessment | 5.0 | 12 | 1.33 | 3.5 | 7 | 1.43 | 6.0 | 20 | 1.70 | 6.5 | 1 | 3.00 | 2.5 | 1 | 1.00 | 6.0 | 14 | 1.71 | 55 | 1.60 | 6 |

*Ranks span a continuum from "information needed and provided" to "information provided but not needed."

of the health and human service providers responded that they had encountered abuse victims which they had not identified at the time and in addition 16 (25.4%) respondents were not sure of whether they had seen unidentified victims.

TABLE 43
RESPONDENTS' PRE-CONFERENCE PERCEPTION OF WHETHER OR NOT THEY HAD PROVIDED SERVICES TO ABUSE VICTIMS BUT FAILED TO IDENTIFY THEM AS SUCH

| Answer | Number of respondents | Percent |
|---|---|---|
| Yes | 27 | 42.9 |
| No | 20 | 31.7 |
| Not sure | 16 | 25.4 |

When queried about their post-conference ability to identify and intervene appropriately with victims of domestic violence 87.7% (N=57) felt they were much more or more skilled, while only 12.3% (N=18) felt their skill level was the same or were unsure of any change (Table 44).

TABLE 44
RESPONDENTS' POST-CONFERENCE PERCEPTION OF THEIR ABILITY TO IDENTIFY AND INTERVENE WITH VICTIMS OF DOMESTIC VIOLENCE

| Answer | Number of respondents | Percent |
|---|---|---|
| Much more skilled | 6 | 9.2 |
| More skilled | 51 | 78.5 |
| The same | 7 | 10.8 |
| Not sure | 1 | 1.5 |

Responses to the question on providing services to individuals in the past who respondents now feel might have been abuse victims were crossed with the respondents' post-conference perception of their ability to appropriately identify and intervene with victims of domestic violence. Twenty-five, or

92.5% of those persons who had answered "yes" to the question of providing services to unidentified victims of abuse, felt more skilled or much more skilled after attending a conference (Table 45).

TABLE 45
PRE-CONFERENCE PROVISION OF SERVICES TO UNIDENTIFIED VICTIMS
BY POST-CONFERENCE ABILITY TO IDENTIFY VICTIMS AND
CARRY OUT APPROPRIATE INTERVENTION

| Responses | | Much more skilled | More skilled | The same | Not sure |
|---|---|---|---|---|---|
| Yes | # | 3 | 22 | 1 | 1 |
| | % | 11.1 | 81.5 | 3.7 | 3.7 |
| No | # | 2 | 13 | 5 | 0 |
| | % | 10.0 | 65.0 | 25.0 | 0 |
| Not sure | # | 1 | 14 | 1 | 0 |
| | % | 6.3 | 87.5 | 6.3 | 0 |
| COLUMN TOTAL | # | 6 | 49 | 7 | 1 |
| | % | 9.5 | 77.8 | 11.1 | 1.6 |

When asked how many people each respondent had shared the conference information with 56% (N=37) had shared the information they learned at the conference with 1 to 6 people, while 39.4% (N=26) had shared the information with over 6 people and only 4.5% (N=3) had shared it with no one (Table 46).

## TABLE 46
## NUMBER OF PERSONS WITH WHOM RESPONDENTS SHARED THE INFORMATION RECEIVED AT THE CONFERENCE

| Number of persons information was shared with | Number of responses | Percent of responses |
|---|---|---|
| 0 | 3 | 4.5 |
| 1-3 | 14 | 21.2 |
| 3-6 | 23 | 34.8 |
| 6-10 | 13 | 19.7 |
| 10-20 | 9 | 13.6 |
| Over 20 | 4 | 6.1 |

When asked if they planned to develop services for victims of domestic violence in their communities 15.2% (N=10) said "yes" and 18.2% (N=12) said "no". Of those responding to the question 30.3% (N=20) were not sure, 27.3% (N=18) were already involved in service development, and 9.1% (N=6) felt the present services were adequate (Table 47). If those respondents who were presently involved in service delivery to victims of domestic violence were combined with those who were going to become involved total involvement increased to 42.5%.

## TABLE 47

## RESPONDENTS' PLANS FOR DEVELOPMENT OF SERVICES FOR VICTIMS OF DOMESTIC VIOLENCE IN THEIR COMMUNITIES

| Plan to develop services | Number | Percent |
|---|---|---|
| Yes | 10 | 15.2 |
| No | 12 | 18.2 |
| Not sure | 20 | 30.3 |
| Am already involved in their development | 18 | 27.3 |
| Present services are adequate | 6 | 9.1 |
| TOTAL | 66 | 100.0 |

# SUMMARY AND RESULTS

## Summary

That domestic violence is a major mental health problem of rural Texas life is documented, recognized and accepted by all researchers into its incidence. It is clear that the unique stresses and conditions of rural life give rise to violence, and that this violence is significantly under-reported.

The consequences of population dispersion, poverty and lack of manpower make adequate rural health service delivery difficult at best. However, when coupled with the characteristics of violence, inadequate understanding of the problem, and lack of knowledge by the health care provider, adequate service delivery becomes an even more significant issue.

Education is the key to this problem. However, too often education is seen as the final step in closing the service delivery gap and thus each new program or idea is burdened with becoming a panacea for the problem. To the contrary, the Rural Texas Domestic Violence Health Professionals Education Program was designed as an initial and circumscribed effort in the establishment of a comprehensive network of services for victims of domestic violence in the state of Texas.

The impetus for developing this program was generated by the following conditions:

1. Awareness of the magnitude of the domestic violence problem in Texas.
2. Concern over the lack of resources and options afforded to rural victims.
3. Knowledge of the need for education on domestic violence issues by rural health and human service providers.
4. Commitment to interface with and become an adjunct to existing networking endeavors.

The immediate goals of the program were to provide rural health care professionals with the knowledge and skills to identify domestic violence victims, utilize existing services and resources, coordinate existing services, create needed services, and design local networks. Through the research and education components of the Rural Texas Domestic Violence Health Professionals Education Program rural health providers, other interested individuals and rural communities have begun to realize the broad scope of domestic violence in rural Texas and to become more attuned to domestic violence indicators.

Rural health providers who participated in the conferences have developed an increased awareness of their larger role as change agents in the community and at the same time become familiar with the network of existing domestic violence services. This has lead to the development of working relationships between rural health providers and domestic violence service providers, thus creating and/or expanding local services, strengthening the existing service network, enhancing public awareness and helping to foster social change. By addressing the rural domestic violence problem through education of rural health providers, the needs of rural victims in Texas have begun to be served.

The next section will detail specific results of the Rural Texas Domestic Violence Health Professionals Education Program and will be followed by conclusions and recommendations.

## Results

The following section represents an effort to highlight some of the more tangible achievements of the Rural Texas Domestic Violence Health Professionals Education Program. Specific results in eight general areas of achievement will be outlined.

### Increased awareness of rural domestic violence throughout the state

--As an awareness of the program developed throughout the state, many agencies, organizations and individuals expressed support and their need for education. Many individuals contacted us to share their frustrations over lack of services and to identify specific rural service delivery problems. This positive response established the level of concern, provided contacts with interested individuals throughout Texas, and helped to focus future efforts.

--Community awareness was increased as the conferences became publicized locally through radio, newspaper and television interviews, public forums and word of mouth.

--Regional awareness about rural domestic violence was enhanced by the extensive media coverage which served as a means of focusing attention on the extent of the problem and need for services.

--Health/human service provider awareness was increased through conference attendance, discussions with conference participants, and exposure to media concerning domestic violence which resulted from the regional conferences.

--Attention was focused on developing rural battered women's shelters, child abuse projects, crisis hotlines, family violence services, and mental health clinics, which aided in their acquisition of funds and volunteers.

--The final report has consolidated the activities of the Rural Texas Domestic Violence Health Professionals Education Program into a concise and cogent written form for dissemination to health/human service providers, state and federal policymakers, private foundations, health/human service organizations and provider associations, domestic violence volunteers and rural residents.

## Creation of new services and improvement of existing services

--As information about the Program spread throughout the state a broad base of interest and support was created. Requests for materials and expressions of the need for education continued to increase throughout the length of the Program, coming not only from individual rural health providers but also from many agencies and organizations. Technical assistance was provided to rural shelters, rural communities, schools of nursing, the Gray Panthers, the staff of the Interim Study on Domestic Violence for the Senate Human Resource Committee, and other interested individuals.

--Technical assistance provided by RTDVHPEP staff has helped with 1) the development of fundraising for existing programs and proposals for the funding of new family violence services, 2) the planning and implementation of crisis hotlines, counseling services, elderly abuse and child abuse projects, battered women's shelters, a mental health clinic, continuing education programs for health/human service providers, volunteer training, and peer support groups, 3) the conduction of needs assessment, 4) the evaluation of existing domestic violence services, and 5) the integration of rural domestic violence service delivery needs into the priorities and objectives of statewide agencies and organizations.

## Creation of a nonmetropolitan health/human service provider database

--The response to the request for the names of rural health care providers was far greater than was originally expected. The projected total of 12,000 to 15,000 names was exceeded by over 12,000, with information coming from individuals, agencies and organizations bringing the final tally to approximately 30,000. Due to the fact that the vast majority of the names were not broken down on a metro-nonmetro basis a very time-consuming process had to be developed to identify the rural providers.

Obtaining comprehensive lists of some professionals was not possible due to the cost of purchasing computer runs. These runs were extremely expensive because special programs were needed to identify only rural providers. Thus the rural health provider database, though extensive, is not as complete as it might have been. However, it remains the only database of this type in the state and contains 10,000 names and addresses.

## Compilation and analysis of rural domestic violence research data

--Survey questionnaires were sent to a geographic and professionally representative sample of 2,241 rural health/human service providers in Texas. Information provided by survey respondents (see Data Analysis section) represents the only statewide rural research on domestic violence from the perspective of health/human service providers available to date and yielded much valuable information. The information is valuable from an educational planning and from a future program design standpoint. The reader should realize that even though the respondents comprised a fairly representative professional and geographic sample of rural health and human service providers, the response rate was low (22%) and those who returned questionnaires could systematically differ from the rest of the population. For this reason additional data was collected in the form of personal interviews followed by evaluations to corroborate survey data as well as to evaluate the educational experience provided by each conference.

--The data obtained served to validate some of the previous assumptions about domestic violence in rural Texas, confirming that significant numbers of all types of violence are occurring in all parts of rural Texas. The data also confirmed that there is a great need for all types of services utilized by rural domestic violence victims.

--The research data served as a basis for increased understanding of rural communities' perception of domestic violence. Respondents perceived their respective communities to be generally supportive toward dealing with domestic violence. However, lack of support and awareness was still perceived as the greatest obstacle to achieving comprehensive domestic violence services and there was a direct correlation between the level of a community's awareness and their level of support. Those communities that were very aware of the problem were very supportive of efforts to deal with it.

--Information on educational needs was garnered from the survey and used to focus the content of the conferences. The data from the conference evaluations and follow-up evaluations verified that the needed information was being provided.

--Interview data revealed that conference participants knew the least about elderly abuse and that more in-depth education was necessary on that topic.

--In general the information gained from the survey, interviews and evaluations served as a basis for gauging and understanding the unique problems of service delivery to domestic violence victims in rural Texas. In addition it provided background information and a means to focus the conference content.

## Development of local, regional and state networks

--Health/human service providers attending the conference met other providers from their region, often for the first time, and exchanged phone numbers, responsibilities, and areas of expertise.

--Utilizing local and regional co-sponsors, facilities and speakers to develop and present each conference has strengthened existing networks and created new ones.

--Local and regional liaisons have resulted from the communication among the co-sponsors and speakers during the development of the conferences.

--Health/human service providers attending the conferences used the opportunity to iron out differences and create and/or strengthen relationships with existing statewide resources such as the Texas Council on Family Violence and the Texas Department of Human Resources.

--Statewide agencies and organizations expanded their networks of health/human service providers in rural Texas through conference and RTDVHPEP participation.

--Provision of technical assistance by RTDVHPEP staff has brought together rural health/human service providers, rural residents, and rural communities to identify and create family violence services.

## Rural health and human service providers knowledgeable and skilled in the identification of and intervention with domestic violence victims

--Six hundred and twelve health and human service providers attended one of five regional conferences. Each conference, though similar in structure to the others, had topics selected to meet the regional needs of the participants. General information on domestic violence was provided along with information on statewide and regional resources for abused children, spouses and elderly, community health assessment, resource and program development, legal issues, diagnosis and intervention with victims, and counseling techniques for crisis intervention.

- --The conferences served as a means of focusing the need for further education and several of the conference co-sponsors are planning to expand on some of the individual topics and offer more in-depth training, while several conference participants are planning conferences in their communities similar to those they attended.

Development of tools for use by rural health and human service providers

- --Domestic Violence: A Bibliography of Relevant Reading Materials and Resource List: Texas Family Violence Statewide Service and Information Agencies were compiled and shared with conference participants and interested individuals. These publications will continue to be available.

- --The materials provided to conference participants included information on elderly abuse, child abuse, and battered women's shelters. These materials can be duplicated by the participants for further dissemination.

- --The creation of comprehensive conference guidelines provided a model for each of the regional conferences and continues to be utilized by health and human service providers, agencies, organizations and universities throughout the state to develop continuing education offerings.

- --A resource library of domestic violence information has been created for use by rural health/human service providers.

Creation of a model

- --The Program has provided an easily replicable model for a cost effective, high impact education program.

- --The final report serves as a step-by-step outline to guide other agencies and organizations in providing similar educational endeavors.

## CONCLUSIONS AND RECOMMENDATIONS

The Rural Texas Domestic Violence Health Professionals Education Program has provided a basis for initial research and education and training efforts on domestic violence in rural Texas. From the information obtained and experience garnered during the research and educational facets of the Program the following conclusions can be drawn and recommendations made. These will provide a foundation for focusing and prioritizing needs for future research endeavors and further program development.

### Conclusions

1. Rural health and human service providers throughout Texas are seeing significant numbers of all types of domestic violence victims.
2. There is a generalized need for all types of information on domestic violence by rural health and human service providers.
3. Rural victims of domestic violence have fewer referral resources than their urban counterparts.
4. There are significant service delivery gaps in all facets of the rural domestic violence service network.
5. The rural communities that are very aware of their domestic violence problem are very supportive of efforts to deal with it.
6. Rural health and human service providers feel isolated from the domestic violence service network.
7. Obstacles to service delivery for victims of domestic violence throughout rural Texas differ from region to region.
8. Many rural Texas communities lack the manpower and financial resources to establish individual comprehensive services for victims.
9. Justices of the peace serve a vital service delivery role to victims in rural Texas.
10. Many rural Texans view the present focus of service delivery to victims of domestic violence in Texas as a threat to the sanctity of the family.
11. Little effort has been made to coalesce rural community resources as well as service needs, resulting in a fragmented picture of rural service service delivery capabilities.

12. Comprehensive information on referral resources has not been made available to rural communities, thus creating a large awareness gap in information on existing services.

13. Rural health and human service providers want more comprehensive education offerings on intervention strategies and program development.

14. Rural health and human service providers need local access to continuing education offerings to minimize lost work time and travel expenses.

## Recommendations for Future Research and Program Development

Recommendation 1: Domestic violence and the rural population.

That state agencies and private foundations provide funds for and complete a statewide rural domestic violence services needs assessment.

That the Texas Legislature establish and fund a mechanism for the effective planning, coordination and delivery of comprehensive domestic violence services to rural Texas.

Recommendation 2: Technical assistance to rural communities and health and human service providers.

That the Texas Department of Human Resources make available, directly or on a subcontract basis, technical assistance to rural communities by individuals with expertise in both domestic violence and rural service delivery.

Recommendation 3: Research on rural domestic violence.

That state agencies and private foundations make available funds to conduct further research in the following areas:

- --urban/rural differences in service delivery problems
- --unique problems and characteristics of rural victims
- --the role of the rural community in domestic violence prevention
- --strategies for rural service delivery.

Recommendation 4: Program design and implementation.

That the Texas Department of Human Resources develop programs in rural areas which are flexible enough in their implementation to allow specific community needs and priorities to be identified and met.

That new and innovative programs, specifically tailored to the needs of the rural population, on a region by region basis, be created and evaluated for their therapeutic effects and economic viability.

That written materials be developed for use by rural citizens in the assessment of domestic violence service needs and in the development of new community services for victims.

That state agencies, private organizations, and academic institutions receive funding to provide ongoing comprehensive continuing education and in-service training in rural areas to local health and human service providers. Such training should include, but not be limited to, information on the latest and most effective identification and intervention techniques, resource development, legal issues, program administration, and network development.

Recommendation 5: Service coordination.

That the Texas Department of Human Resources develop mechanisms to ensure the coordination of services to all types of domestic violence victims.

Recommendation 6: Increasing public awareness.

That the Texas Legislature appropriate funds to expand public and professional awareness of domestic violence issues. Such an awareness campaign should include, but not be limited to, public service announcements, written materials and education forums.

Recommendation 7: Allocation of services and health and human service professionals

That state agencies and organizations examine whether they are allotting sufficient monies, services and personnel to rural areas when distance, time and present lack of service are considered.

That state agencies and organizations providing services to rural areas, reallocate funds and personnel to bridge the gaps in services, and begin to create services where none exist.

That shelters for battered women allot a certain percentage of their budgets for rural outreach and service provision in their rural catchment areas.

### Recommendation 8: Education of future health and human service professionals

That institutions charged with the education of health and human service providers examine their curricula to determine whether they are providing the knowledge and skills necessary to appropriately identify and intervene with domestic violence victims.

# LIST OF REFERENCES

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6. Citizens for Human Development. Statewide Mental Health Needs Survey. Austin, Texas: Citizens for Human Development, 1982.

7. Comment on conference evaluation form for Domestic Violence and Rural Texas: A Conference for Health Professionals, held in Nacogdoches, Texas by the Rural Texas Domestic Violence Health Professionals Education Program, 1983.

8. Comment on conference evaluation form for Domestic Violence and Rural Texas: A Conference for Health Professionals, held in Lubbock, Texas by the Rural Texas Domestic Violence Health Professionals Education Program, 1983.

9. Comment on conference evaluation form for Domestic Violence and Rural Texas: A Conference for Health Professionals, held in Alpine, Texas by the Rural Texas Domestic Violence Health Professionals Education Program, 1983.

10. Comment on conference evaluation form for Domestic Violence and Rural Texas: A Conference for Health Professionals, held in Gainesville, Texas by the Rural Texas Domestic Violence Health Professionals Education Program, 1983.

# APPENDIX A

## Rural Texas Domestic Violence Survey Questionnaire

# Rural Texas Domestic Violence[1] Health Professionals Education Program Survey Questionnaire

Directions

Please answer the following questions by checking or filling in the appropriate spaces. Except for the last section which asks for personal comments, this questionnaire should take you no longer than fifteen minutes to complete. Any information you contribute will be anonymous. Again, thank you for your time and invaluable help. (Please refer to the back of the last page for mailing instructions.)

1. Check any of the services you provide:
   _____ Health services
   _____ Legal services
   _____ Social services
   _____ Religious services
   _____ Other (specify) ______________________________________________

2. What is your profession?
   _____ Physician
   _____ Nurse, nurse practitioner, physician's assistant
   _____ EMT, paramedic, ECA
   _____ Social worker, psychologist, mental health worker, counselor
   _____ Hospital administrator
   _____ Clinic administrator, community center administrator, child care facility administrator
   _____ Clergy
   _____ Justice of the Peace
   _____ Other (specify) ______________________________________________

3. Which categories best describe your professional duties?
   _____ Case work (social/psychological)
   _____ Direct patient care (hospital, clinic)
   _____ Direct patient care (home)
   _____ Administration
   _____ Law enforcement
   _____ Other (specify) ______________________________________________

4. Describe the area in which you work:
   a. Population: _____ Less than 1,000
   _____ 1,000 to 2,500
   _____ 2,500 to 5,000
   _____ 5,000 to 10,000
   _____ 10,000 to 25,000
   _____ 25,000 to 50,000
   _____ Over 50,000

---

[1] The term "domestic violence" refers to physical abuse, neglect, exploitation, and other forms of mistreatment of any family member (women, children, men and the elderly).

(OVER)

b. Circle the counties that you serve in the list below:

Anderson
Andrews
Angelina
Aransas
Archer
Armstrong
Atascosa
Austin
Bailey
Bandera
Bastrop
Baylor
Bee
Bell
Bexar
Blanco
Borden
Bosque
Bowie
Brazoria
Brazos
Brewster
Briscoe
Brooks
Brown
Burleson
Burnet
Caldwell
Calhoun
Callahan
Cameron
Camp
Carson
Cass
Castro
Chambers
Cherokee
Childress
Clay
Cochran
Coke
Coleman
Collin
Collingsworth
Colorado
Comal
Comanche
Concho
Cooke
Coryell
Cottle
Crane
Crockett
Crosby
Culberson
Dallam
Dallas
Dawson
Deaf Smith
Delta
Denton
DeWitt
Dickens
Dimmit
Donley
Duval
Eastland
Ector
Edwards
Ellis
El Paso
Erath
Falls
Fannin
Fayette
Fisher
Floyd
Foard
Fort Bend
Franklin
Freestone
Frio
Gaines
Galveston
Garza
Gillespie
Glasscock
Goliad
Gonzales
Gray
Grayson
Gregg
Grimes
Guadalupe
Hale
Hall
Hamilton
Hansford
Hardeman
Hardin
Harris
Harrison
Hartley
Haskell
Hays
Hemphill
Henderson
Hidalgo
Hill
Hockley
Hood
Hopkins
Houston
Howard
Hudspeth
Hunt
Hutchinson
Irion
Jack
Jackson
Jasper
Jeff Davis
Jim Hogg
Jim Wells
Johnson
Jones
Karnes
Kaufman
Kendall
Kenedy
Kent
Kerr
Kimble
King
Kinney
Kleberg
Knox
Lamar
Lamb
Lampasas
LaSalle
Lavaca
Lee
Leon
Liberty
Limestone
Lipscomb
Live Oak
Llano
Loving
Lubbock
Lynn
McCulloch
McLennan
McMullen
Madison
Marion
Martin
Mason
Matagorda
Maverick
Medina
Menard
Midland
Milam
Mills
Mitchell
Montague
Montgomery
Moore
Motley
Nacogdoches
Navarro
Newton
Nolan
Nueces
Ochiltree
Oldham
Orange
Palo Pinto
Panola
Parker
Parmer
Pecos
Polk
Potter
Presidio
Rains
Randall
Reagan
Real
Red River
Reeves
Refugio
Roberts
Robertson
Rockwall
Runnels
Rusk
Sabine
San Augustine
San Jacinto
San Patricio
San Saba
Schleicher
Scurry
Shackelford
Shelby
Sherman
Smith
Somervell
Starr
Stephens
Sterling
Stonewall
Sutton
Swisher
Tarrant
Taylor
Terrell
Terry
Throckmorton
Titus
Tom Green
Travis
Trinity
Tyler
Upshur
Upton
Uvalde
Val Verde
Van Zandt
Victoria
Walker
Waller
Ward
Washington
Webb
Wharton
Wheeler
Wichita
Wilbarger
Willacy
Williamson
Wilson
Winkler
Wise
Wood
Yoakum
Young
Zapata
Zavala

c. What is the major local economic base?

_____ Agriculture
_____ Ranching
_____ Industry
_____ Mining
_____ Other (specify)

d. Have there been any major changes in the composition of the **population or** the economic base of your service population during the last **4 years? If** you answered yes, please specify what type of change.

_____ Yes
_____ No

Type of change (example: local factory opening or shutdown, influx of unskilled labor):

______________________________________________

If the answer to 4d was yes, has this change increased or decreased the amount of domestic violence in your area?

_____ Increased
_____ Decreased

5. Describe the cultural/ethnic composition of your service population ("1" indicates those most frequently served, "4" indicates those least frequently served).

_____ Anglo
_____ Black
_____ Mexican American
_____ Oriental
_____ Other (specify) ____________________________

6. Describe the religious affiliation of your service population ("1" indicates those most frequently served, "7" indicates those least frequently served).

_____ Catholic
_____ Jewish
_____ Episcopal
_____ Christian
_____ Baptist
_____ Methodist
_____ Presbyterian
_____ Other (specify)_________________________

7. Describe your perception of your community's level of awareness of domestic violence. (Check the one which best applies.)

_____ Very aware of problem
_____ Aware of problem
_____ Somewhat aware of problem
_____ Not very aware of problem
_____ Unaware of problem

8. Describe your perception of your community's attitude toward dealing with domestic violence. (Check the one which best applies.)

_____ Positive/support from individuals, government, business, law enforcement
_____ Mixed/support mostly from individuals
_____ Those who are aware are supportive
_____ Indifference on the part of the community
_____ Negative reaction/view problem as political/feminist issue
_____ Negative reaction from churches/pro family groups
_____ Negative attitude toward help from agencies and outsiders

(OVER)

9. Rank the following obstacles to achieving comprehensive domestic violence services in your community ("1" indicates the greatest obstacle, "10" indicates the least obstacle).

_____ Lack of client transportation
_____ Distance between your community and nearest health, MHMR and shelter services
_____ Lack of support or awareness of health professionals and agencies
_____ Lack of community support or community unaware or denies problem
_____ Negative attitudes such as: beating is OK/don't pry into family life/blame victim
_____ Cultural barriers such as: language barrier or family will only reach out to "helper" of same cultural orientation
_____ Lack of money/funds for personnel and materials
_____ Poor case reporting/case finding system
_____ Reluctance to report child abuse
_____ Other (specify) ______________________________

10. To be better able to service domestic violence victims, what are your needs for information and training? (Rank each one: 1 indicates most needed, 2 somewhat needed, 3 not needed.)

_____ General information
_____ Information on diagnosis and treatment
_____ Counseling techniques
_____ Building community support
_____ Resources and referrals
_____ How to start a shelter
_____ Fundraising
_____ Working with clients from other cultures
_____ Solving geographic and transportation problems

11. For each victim category indicate with a check mark how many cases you have encountered during the last year.

| Victim | 0-3 cases | 3-6 cases | 6-10 cases | over 10 cases |
|---|---|---|---|---|
| Boy (0-18 years) | | | | |
| Girl (0-18 years) | | | | |
| Woman (18-64 years) | | | | |
| Man (18-64 years) | | | | |
| Elderly man (65 years or over) | | | | |
| Elderly woman (65 years or over) | | | | |

12. For each service listed below, indicate the number of times used, evaluate the quality of support you received, and prioritize the need for that service.

| Write in the number of times each was used for referral | Quality of Support received (check one) | | Priority of services needed (check one) | | |
|---|---|---|---|---|---|
| | good | poor | greatly needed | somewhat needed | not needed |
| _____ police | | | | | |
| _____ churches | | | | | |
| _____ battered women's shelters | | | | | |
| _____ child welfare | | | | | |
| _____ social service agencies | | | | | |
| _____ hospital | | | | | |
| _____ physician | | | | | |
| _____ legal aid | | | | | |
| _____ emergency room | | | | | |
| _____ court | | | | | |
| _____ lawyer | | | | | |
| _____ nurse | | | | | |
| _____ emergency medical services | | | | | |
| _____ Department of Human Resources | | | | | |
| _____ counselors | | | | | |
| _____ other (specify) ________________ | | | | | |

(OVER)

13. Are there any other factors which you feel interfere with your ability to serve domestic violence victims?

14. Please add any comments you have about the questionnaire, your concerns about domestic violence in rural areas or your educational needs.

Please return to: Karen Mountain, R.N., M.S.N.
Project Coordinator
Rural Texas Domestic Violence
Health Professionals Education Program
Texas Rural Health Field Services Program
1700 Red River
Austin, TX 78701-1499

If you have any questions, please feel free to call. The number is (512)-471-7311.

# APPENDIX B

## Conference Development Guidelines

Title: Domestic Violence in Rural Texas: Issues and Resources for Health Professionals

Conference Development Guidelines

Sponsored by: Rural Texas Domestic Violence Health Professionals Education Program and the Texas Council on Family Violence

Funded by: The Hogg Foundation for Mental Health

# Conference Content and Format Guidelines

## Overview

The following set of guidelines is designed to serve as a resource in the development of each of the regional conferences being sponsored by the Rural Texas Domestic Violence Health Professionals Education Program in coordination with the Texas Council on Family Violence.

The guidelines were developed to reflect the purpose and program approach of the Rural Texas Domestic Violence Health Professionals Education Program. By providing direction in content and format development, there will be both continuity among the individual workshops and flexibility in the specific content areas. Continuity among the conferences will insure that the same general information on the problem and the available statewide resources is presented to all participants. Flexibility in the conferences' focus and in specific content areas will allow each region to use local experts as conference speakers and focus the content to meet regional information and learning needs.

## Rural Texas Domestic Violence
## Health Professionals Education Program
## Purpose

The purpose of the Rural Texas Domestic Violence Health Professionals Education Program is to educate health professionals in rural areas to:

1) Assess and intervene with domestic violence victims
2) Discuss available resources and referral agencies
3) Identify community health resources
4) Identify community health service weaknesses
5) Report violence to local law enforcement
6) Link local rural health service providers and other domestic violence service providers

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7) Educate other local health providers to develop volunteer oriented human service networks.

**Purpose 1:** Assess and intervene with domestic violence victims.
**Purpose 7:** Educate other local health providers to develop volunteer oriented human service networks.

Terminal Objective: By the end of the conference each participant should be able to identify strategies for diagnosis of and intervention with victims of domestic violence and be able to act as a local resource on domestic violence.

En route objectives: In order to accomplish the terminal objective the participant should be able to:

1) Discuss the extent of the domestic violence problem in Texas

2) Identify two characteristics of the violent relationship

3) Discuss the cycle of violence

4) Participate in a discussion concerning the role of the health provider in the delivery of health care services to domestic violence victims

5) Identify a domestic violence victim.

General Content Outline:

I. Overview of the extent of violence

- A. Child abuse
- B. Battered spouses
- C. Elderly abuse

II. The dynamics of violence

- A. The relationship between child abuse, battered spouses, elderly abuse
- B. The stages of the cycle of violence
  1. Tension buildup
  2. Explosion
  3. Restitution

III. Factors related to violent interactions

- A. Stress
- B. Economics
- C. Drugs and alcohol
- D. Violence in our society

IV. Characteristics of the violent family

- A. Socio-economic status
- B. Isolation
- C. Length and type of violence
- D. Violence as a resource
- E. Rural/urban differences

V. Characteristics of the victim

- A. Dependency and violence
- B. Psychological factors
- C. Physical factors

VI. The role of the health provider in assessment of and intervention with domestic violence victims

- A. Coming in contact with victims: where and when
- B. The role of suspicion in recognizing victims
- C. Asking the right questions
- D. Determining the extent of danger
- E. Exploring alternatives
- F. Knowledge of other resources and referrals
- G. Ongoing support; leaving the door open

Suggestions for optional areas for content development:

1. Counseling and crisis intervention techniques
2. Specific workshops on one of the victim categories, i.e. child, woman, or elderly
3. Diagnosis and treatment of physical abuse: the role of the physician, nurse, EMT and other professionals

Suggested media:

"In need of special attention," 16mm color film narrated by Loretta Swit. This film teaches hospital personnel to recognize the symptoms of spouse abuse and to intervene in family violence cases. 17 minutes.

"Assessing Child Abuse/Neglect," slide-tape presentation on diagnosis of child abuse. 20 minutes.

Purpose 2: Discuss available resources and referral agencies.
Purpose 6: Link local rural health service providers and other domestic violence service providers.

Terminal Objective: By the end of the conference each participant should be aware of the statewide resources and referral agencies for domestic violence victims.

En route objectives: In order to accomplish the terminal objective the participant should be able to:

1. Identify one resource or referral agency for each: abused children, battered women, abused elderly
2. Discuss the services provided by two agencies to their community
3. Refer a domestic violence victim to the appropriate agency.

General Content Outline:

I. History of services to domestic violence victims

   A. First state agency services
   B. Grass-roots efforts
   C. Volunteer organizations

II. History of shelters in Texas

   A. First ones began in 1978
      1. What they offered initially
   B. How they grew
      1. Developed different focuses
   C. Common to all
      1. Inadequate to meet need
      2. Need to educate community and coalesce services

III. History of TCFV

   A. When and why it began
      1. How it worked in early stages--all volunteers
   B. What it accomplished--state legislation funding shelters
      1. 2-year demonstration grant
      2. Everyone funded 1982
   C. Funded office opened
      1. What it accomplished 1982
      2. Plans for 1983
   D. Services offered by TCFV
      1. Technical assistance
         a. Board development
         b. Fundraising
         c. Organizational issue
         d. Programs for batterers
         e. Services for children
      2. Lobbying--legislative reform
         a. 1984 appropriation
      3. Subcontract--DHR--site visits
      4. Liaison with DHR--conduit for state funds

IV. What's available in your area

   A. Shelters
   B. Developing programs
   C. Other resources

V. What a shelter and service program can do

A. Identify needs
B. Meet some (probably not all) needs
C. Raise community level of awareness
D. Identify service gaps
E. Coalesce different kinds of service providers
F. Serve as a resource for information, networking, consultation on needs

Suggestions for optional areas of content development:

1. Agency profiles
   a. Child Welfare
   b. Area shelters
   c. Protective services for the elderly
2. New models for service delivery in rural areas
3. The role of the advocate in obtaining services for victims

Purpose 3: Identify community health resources.
Purpose 4: Identify community health service weaknesses.

Terminal Objective: By the end of the conference each participant should be able to assess community resources and gaps with a focus on services for domestic violence victims.

En route objectives: In order to accomplish the terminal objective the participant should be able to:

1. Identify three components of the community assessment process

2. Discuss a procedure for identifying a community's domestic violence services

3. Discuss a procedure for identifying gaps in a community's domestic violence services

General Content Outline:

I. What is a community health assessment

A. Definition
B. Difference between community assessment and community health assessment
C. Using community health assessment as a problem-solver
D. The relationship of community health assessment to community development

II. The process of community health assessment

A. Developing a profile of community characteristics
B. Changes in characteristics over time
C. Identifying resources and gaps

III. Components of a community health assessment

- A. General and geographic information
- B. Population
- C. Health characteristics
- D. Social and cultural
- E. Environmental services
- F. Law enforcement services
- G. Health services

Suggestions for optional content development:

1. Domestic violence program development--a how-to approach
2. Grant writing and foundation funding
3. How to evaluate people oriented programs
4. A guide to community assessment
5. Coordinating services in the small community

Purpose 5: Report violence to local law enforcement.

Terminal Objective: By the end of the conference each participant should be able to identify the role of law enforcement in aiding victims of domestic violence.

En route objectives: In order to accomplish the terminal objective the participant should be able to:

1. Identify two types of domestic violence which require reporting

2. Discuss the legal responsibilities of the health care provider in domestic violence cases

3. Describe the type of information which needs to be reported

4. Identify one law which protects domestic violence victims.

General Content Outline:

I. Laws protecting victims of domestic violence

- A. Child abuse
- B. Spouse abuse
- C. Elderly abuse

II. The role of the law enforcement officer

III. Legal responsibilities of the health care provider

- A. Assessing the legal system
- B. Legal obligations in reporting domestic violence

IV. The hows and whys of reporting domestic violence

V. Building a case

- A. Written documentation
- B. Other evidence

VI. The role of the criminal justice system in the deterrence of violence

Suggestions for optional areas of content development:

1. Alternative enforcement techniques, i.e. programs for men who batter
2. Law enforcement training: the role of the health provider
3. Gaps in legal remedies for domestic violence victims

Suggested media:

"A Family Affair," 16mm color film. This documentary drama was designed to outline legal remedies available for domestic abuse. 28 minutes.

# APPENDIX C

## Conference Evaluation Form

Domestic Violence in Rural Texas:
A Conference for Health Professionals

EVALUATION FORM

| | Poor | | | | Excellent |
|---|---|---|---|---|---|
| 1. In general, how would you rate this conference? | 1 | 2 | 3 | 4 | 5 |
| 2. How well do you feel that this conference prepared you to: | | | | | |
| a. Assess and intervene with victims | 1 | 2 | 3 | 4 | 5 |
| b. Identify statewide resources and referral agencies | 1 | 2 | 3 | 4 | 5 |
| c. Assess community resources | 1 | 2 | 3 | 4 | 5 |
| d. Identify the role of law enforcement | 1 | 2 | 3 | 4 | 5 |

3. What did you like best about the conference?

4. What did you like least about the conference?

5. What changes could be made to improve this conference?

# APPENDIX D

## Interview Form

Rural Texas Domestic Violence[1] Health Professionals Education Program

## Interview Form

1. As a rural provider, what do you feel are the unique problems and needs related to the delivery of services to domestic violence victims in rural Texas?

2. Is there a difference in your community's attitude toward dealing with child abuse, spouse abuse, and abuse of the elderly?

( ) Yes ( ) No

3. If yes, how does your community's attitude differ for each?

---

[1] The term "domestic violence" refers to physical abuse, neglect, exploitation, and other forms of mistreatment of any family member (women, children, men and the elderly).

4. For each victim category indicate with a check mark how many cases you have encountered during the last year.

| Victim | 0 cases | 1-2 cases | 3-5 cases | 6-10 cases | over 10 cases |
|---|---|---|---|---|---|
| Boy (0-18 years) | | | | | |
| Girl (0-18 years) | | | | | |
| Woman (18-64 years) | | | | | |
| Man (18-64 years) | | | | | |
| Elderly man (65 years or over) | | | | | |
| Elderly woman (65 years or over) | | | | | |

5. Of the three groups of domestic violence victims (children, spouses, and elders), which do you feel you know the least about? (check one)

( ) child abuse
( ) spouse abuse
( ) elderly abuse

6. To best serve the group identified above, what are your specific needs for information and training?

# APPENDIX E

## Follow-up Evaluations

# Rural Domestic Violence Conference:
# Follow-Up Evaluation

Directions

Please answer the following questions by checking or filling in the appropriate spaces. This questionnaire should take you no longer than ten minutes to complete. Any information you contribute will be anonymous. Again, thank you for your time and invaluable help. (Please refer to the back of the last page for mailing instructions.)

1. What is your profession? (check one)

_____ Physician
_____ Nurse, nurse practitioner, physician's assistant
_____ EMT, paramedic, ECA
_____ Social worker, psychologist, mental health worker, counselor
_____ Hospital administrator
_____ Clinic administrator, community center administrator, child care facility administrator
_____ Clergy
_____ Justice of the Peace
_____ Other (specify) ______________________________________________

2. In which of the following areas did the conference provide/not provide information you needed to improve your ability to serve victims of domestic violence?

Rank each one:
(1) indicates provided needed information
(2) indicates provided information not needed
(3) indicates information needed but not provided

_____ General information
_____ Diagnosis and intervention with victims
_____ Counseling techniques
_____ Building community support
_____ Statewide and regional resources
_____ Legal and law enforcement issues
_____ Fundraising
_____ Community health assessment

3. Looking back on individuals you have provided services to in the past, do you now feel that some of them were abuse victims which you may not have identified at the time? (check one)

_____ Yes
_____ No
_____ Not sure

4. Compared to how you felt before the conference, how do you now feel about your ability to identify and intervene appropriately with victims of domestic violence? (check one)

_____ Much more skilled
_____ More skilled
_____ The same
_____ Not sure

(OVER)

5. Have you shared the information you received at the conference with: (check one)

_____ No one
_____ 1-2 people
_____ 3-5 people
_____ 6-9 people
_____ 10-20 people
_____ Over 20 people

6. Do you plan on developing services for victims of domestic violence in your community? (check one)

_____ Yes
_____ No
_____ Not sure
_____ Am already involved in their development
_____ Present services are adequate

Please fold, staple, stamp, and return. If you have any questions, please feel free to call. The number is 512-471-7311.

- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -

Stamp

Karen Mountain, R.N., M.S.N.
Project Coordinator
Rural Texas Domestic Violence
Health Professionals Education Program
Texas Rural Health Field Services Program
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# APPENDIX F

## Survey Data on Obstacles to Achieving Comprehensive Domestic Violence Services in Rural Areas

## TABLE 48
## OBSTACLES TO ACHIEVING COMPREHENSIVE DOMESTIC VIOLENCE SERVICES IN RURAL AREAS

| Obstacles | Obstacle Rating* | | | | | | | | | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | 1 | | 2 | | 3 | | 4 | | 5 | | 6 | | 7 | | 8 | | 9 | | 10 | |
| | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % | No. | % |
| Lack of client transportation | 19 | 6.4 | 22 | 7.4 | 28 | 9.4 | 16 | 5.4 | 37 | 12.4 | 30 | 10.0 | 28 | 9.4 | 39 | 13.0 | 50 | 16.7 | 30 | 10.0 |
| Distance between your community and health, MHMR, and shelter services | 61 | 19.1 | 27 | 8.4 | 19 | 5.9 | 22 | 6.9 | 23 | 7.2 | 33 | 10.3 | 30 | 9.4 | 51 | 15.9 | 25 | 7.8 | 29 | 9.1 |
| Lack of support or awareness of health professionals and agencies | 30 | 9.7 | 29 | 9.4 | 16 | 5.2 | 28 | 9.1 | 29 | 9.4 | 33 | 10.7 | 49 | 15.9 | 35 | 11.3 | 35 | 11.3 | 25 | 8.1 |
| Lack of support or awareness by community | 90 | 28.8 | 31 | 9.9 | 19 | 6.1 | 31 | 9.9 | 36 | 11.5 | 28 | 9.0 | 20 | 6.4 | 27 | 8.7 | 11 | 3.5 | 19 | 6.1 |
| Negative attitudes such as: beating is OK/ don't pry | 55 | 17.7 | 41 | 13.2 | 31 | 10.0 | 27 | 8.7 | 27 | 8.7 | 18 | 5.8 | 36 | 11.6 | 27 | 8.7 | 25 | 8.1 | 23 | 7.4 |
| Cultural barriers | 44 | 14.3 | 36 | 11.7 | 44 | 14.3 | 32 | 10.4 | 28 | 9.1 | 35 | 11.4 | 28 | 9.1 | 22 | 7.2 | 20 | 6.5 | 18 | 5.9 |
| Lack of money/ funds for personnel and materials | 89 | 27.6 | 40 | 12.4 | 44 | 13.6 | 31 | 9.6 | 28 | 8.7 | 26 | 8.0 | 24 | 7.4 | 20 | 6.2 | 14 | 43 | 7 | 2.2 |
| Poor case reporting/case finding systems | 63 | 20.1 | 37 | 11.8 | 51 | 16.3 | 42 | 13.4 | 42 | 13.4 | 21 | 6.7 | 16 | 5.1 | 10 | 3.2 | 19 | 6.1 | 12 | 3.8 |
| Reluctance to report child abuse | 82 | 24.5 | 43 | 12.8 | 34 | 10.1 | 42 | 12.5 | 34 | 10.1 | 24 | 7.2 | 20 | 6.0 | 17 | 5.1 | 28 | 8.4 | 10 | 3.0 |
| Other | 14 | 25.0 | 7 | 12.5 | 3 | 5.4 | 1 | 1.8 | 2 | 3.6 | 2 | 3.6 | Missing | | 1 | 1.8 | 1 | 1.8 | 24 | 57.4 |

Obstacle Rating Scale: "1" indicates the greatest obstacle, "10" indicates the least obstacle.

## TABLE 49
## OBSTACLES TO ACHIEVING COMPREHENSIVE DOMESTIC VIOLENCE SERVICES BY REGION

| Obstacles | Region | | | | | | | | | | | | | | | | | | Total | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| | West Texas | | | Northwest Texas | | | South Texas | | | Central Texas | | | East Texas | | | Southeast Texas | | | | |
| | N | M | R | N | M | R | N | M | R | N | M | R | N | M | R | N | M | R | N | M |
| Lack of client transportation | 7 | 7.57 | 9 | 8 | 6.38 | 8 | 8 | 6.00 | 8 | 8 | 5.75 | 9 | 6 | 5.17 | 9 | 5 | 5.80 | 8 | 42 | 6.14 |
| Distance between your community and health, MHMR and shelter services | 8 | 4.88 | 7 | 8 | 5.50 | 5.5 | 8 | 3.75 | 2 | 10 | 4.90 | 7 | 6 | 4.33 | 5 | 8 | 3.75 | 4 | 48 | 4.54 |
| Lack of support or awareness of health professionals and agencies | 7 | 6.57 | 8 | 7 | 7.00 | 9 | 7 | 8.14 | 9 | 10 | 3.80 | 3 | 7 | 5.00 | 8 | 6 | 4.83 | 5 | 44 | 5.77 |
| Lack of support or awareness by community | 7 | 4.86 | 6 | 7 | 6.00 | 7 | 8 | 5.63 | 7 | 9 | 4.22 | 4 | 6 | 4.17 | 4 | 8 | 3.13 | 2 | 45 | 4.64 |
| Negative attitudes such as beating is OK/don't pry | 9 | 3.78 | 3 | 8 | 5.50 | 5.5 | 8 | 4.38 | 3 | 8 | 4.88 | 6 | 5 | 4.80 | 7 | 8 | 4.88 | 7 | 46 | 4.67 |
| Cultural barriers | 7 | 4.71 | 5 | 10 | 5.20 | 4 | 9 | 4.56 | 4 | 8 | 4.75 | 5 | 5 | 4.60 | 6 | 6 | 6.17 | 9 | 45 | 4.98 |
| Lack of money/funds for personnel and materials | 8 | 4.63 | 2 | 1 | 5.00 | 3 | 9 | 3.45 | 1 | 10 | 2.00 | 1 | 5 | 3.60 | 3 | 8 | 1.75 | 1 | 50 | 3.42 |
| Poor case reporting/case finding systems | 8 | 3.13 | 2 | 8 | 3.75 | 1 | 9 | 5.00 | 5.5 | 9 | 3.67 | 2 | 7 | 2.57 | 1 | 7 | 4.86 | 6 | 48 | 3.85 |
| Reluctance to report child abuse | 10 | 2.20 | 1 | 8 | 3.88 | 2 | 7 | 5.00 | 5.5 | 8 | 5.25 | 8 | 6 | 3.50 | 2 | 10 | 3.70 | 3 | 49 | 3.84 |

Obstacle Rating Scale: "1" indicates the greatest obstacle,
"10" indicates the least obstacle
Note: "Other" not processed

N = Number
M = Mean
R = Rank

## APPENDIX G

## Survey Data on Conference Interviews

## TABLE 50

## NUMBERS AND TYPES OF VICTIMS SEEN BY RESPONDENTS TO INTERVIEWS FROM ALPINE CONFERENCE

| Victim | Cases | | | | | Responses |
|---|---|---|---|---|---|---|
| | 0 cases | 1-2 cases | 3-5 cases | 6-10 cases | Over 10 cases | |
| Boy (0-18 yrs.) | 4 | 0 | 0 | 1 | 0 | 5 |
| Girl (0-18 yrs.) | 4 | 0 | 0 | 0 | 1 | 5 |
| Woman (18-64 yrs.) | 3 | 1 | 0 | 0 | 1 | 5 |
| Man (18-64 yrs.) | 4 | 1 | 0 | 0 | 0 | 5 |
| Elderly man (over 64) | 5 | 0 | 0 | 0 | 0 | 5 |
| Elderly woman (over 64) | 5 | 0 | 0 | 0 | 0 | 5 |
| COLUMN TOTALS | 25 | 2 | 0 | 1 | 2 | 30 |

## TABLE 51

## NUMBERS AND TYPES OF VICTIMS SEEN BY RESPONDENTS TO INTERVIEW FROM LUBBOCK CONFERENCE

| Victims | Cases | | | | | Responses |
|---|---|---|---|---|---|---|
| | 0 cases | 1-2 cases | 3-5 cases | 6-10 cases | Over 10 cases | |
| Boy (0-18 yrs.) | 4 | 0 | 0 | 1 | 0 | 5 |
| Girl (0-18 yrs.) | 1 | 3 | 0 | 0 | 1 | 5 |
| Woman (18-64 yrs.) | 0 | 3 | 0 | 1 | 1 | 5 |
| Man (18-64 yrs.) | 2 | 2 | 1 | 0 | 0 | 5 |
| Elderly man (over 64) | 3 | 2 | 0 | 0 | 0 | 5 |
| Elderly woman (over 64) | 0 | 5 | 0 | 0 | 0 | 5 |
| COLUMN TOTAL | 10 | 15 | 1 | 2 | 2 | 30 |

## TABLE 52

## NUMBERS AND TYPES OF VICTIMS SEEN BY RESPONDENTS TO INTERVIEWS FROM VICTORIA CONFERENCE

| Victim | Cases | | | | | Responses |
|---|---|---|---|---|---|---|
| | 0 cases | 1-2 cases | 3-5 cases | 6-10 cases | Over 10 cases | |
| Boy (0-18 yrs.) | 0 | 1 | 2 | 1 | 1 | 5 |
| Girl (0-18 yrs.) | 0 | 1 | 1 | 2 | 1 | 5 |
| Woman (18-64 yrs.) | 0 | 1 | 0 | 1 | 3 | 5 |
| Man (18-64 yrs.) | 2 | 3 | 0 | 0 | 0 | 5 |
| Elderly man (over 64) | 2 | 2 | 1 | 0 | 0 | 5 |
| Elderly woman (over 64) | 1 | 2 | 2 | 0 | 0 | 5 |
| COLUMN TOTAL | 5 | 10 | 6 | 4 | 5 | 30 |

## TABLE 53

## NUMBERS AND TYPES OF VICTIMS SEEN BY RESPONDENTS TO INTERVIEWS FROM GAINESVILLE CONFERENCE

| Victim | Cases | | | | | Responses* |
|---|---|---|---|---|---|---|
| | 0 cases | 1-2 cases | 3-5 cases | 6-10 cases | Over 10 cases | |
| Boy (0-18 yrs.) | 1 | 2 | 1 | 0 | 0 | 4 |
| Girl (0-18 yrs.) | 1 | 3 | 0 | 0 | 0 | 4 |
| Woman (18-64 yrs.) | 0 | 1 | 3 | 0 | 0 | 4 |
| Man (18-64 yrs.) | 3 | 1 | 0 | 0 | 0 | 4 |
| Elderly man (over 64) | 4 | 0 | 0 | 0 | 0 | 4 |
| Elderly woman (over 64) | 2 | 2 | 0 | 0 | 0 | 4 |
| COLUMN TOTAL | 11 | 9 | 4 | 0 | 0 | 24 |

*One person omitted this question.

TABLE 54

NUMBER AND TYPES OF VICTIMS SEEN BY RESPONDENTS TO INTERVIEWS FROM NACOGDOCHES CONFERENCE

| Victim | Cases | | | | | Responses |
|---|---|---|---|---|---|---|
| | 0 cases | 1-2 cases | 3-5 cases | 6-10 cases | Over 10 cases | |
| **Boy** (0-18 yrs.) | 3 | 2 | 0 | 0 | 0 | 5 |
| Girl (0-18 yrs.) | 1 | 4 | 0 | 0 | 0 | 5 |
| Woman (18-64 yrs.) | 0 | 2 | 2 | 0 | 1 | 5 |
| Man (18-64 yrs.) | 4 | 1 | 0 | 0 | 0 | 5 |
| Elderly man (over 64) | 5 | 0 | 0 | 0 | 0 | 5 |
| Elderly woman (over 64) | 3 | 2 | 0 | 0 | 0 | 5 |
| COLUMN TOTAL | 16 | 11 | 2 | 0 | 1 | 30 |